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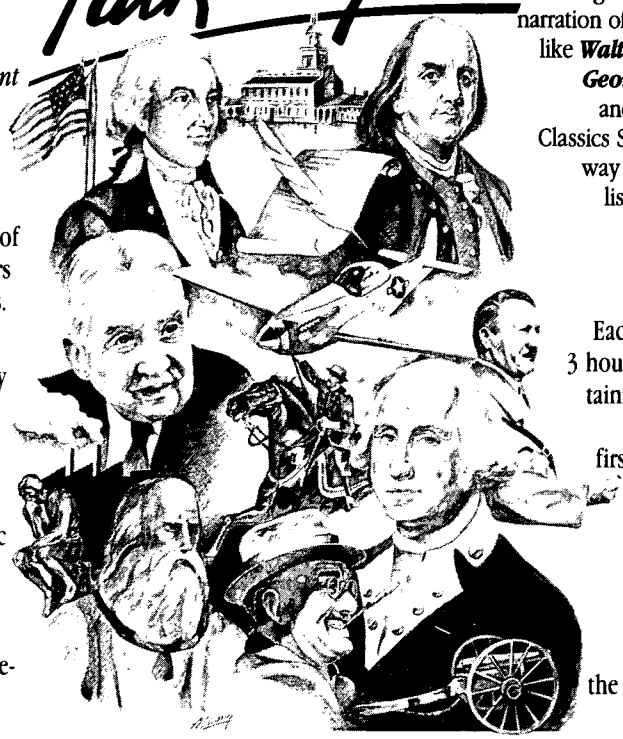

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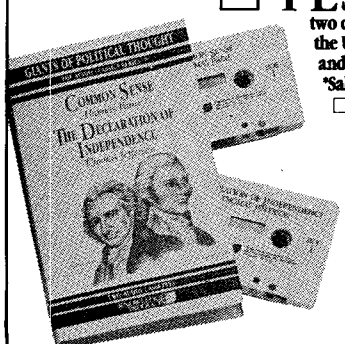

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Free Minds and Free Markets

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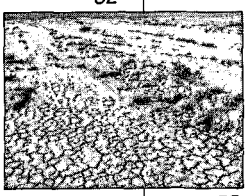

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POLICY BUST

VIRGINIA I. POSTREL

Serious people don't spend much time talking about breast implants—at least if they want to continue to be considered serious people. Artificially enhanced decollatage is a subject for *Geraldo*, not *Nightline*; *The Star*, not *The New York Times*.

Until recently. The latest manifestation of the Food and Drug Administration's campaign to enlarge its regulatory empire is an attack on silicone-gel breast implants. The FDA has called for a moratorium on sales of the implants and may very well wind up outlawing them.

The evidence against the implants is of varying quality. In many women, they lead to scarring between the implant and the inside of the breast, a condition that may be trivial, quite painful, or serious enough to require additional surgery. Cosmetic surgeons routinely warn implant patients of this risk.

Another undisputed risk is that implants block mammograms, making early-stage breast cancers more difficult to detect. But the availability of implants for reconstructive surgery also leads some women, who would otherwise be deterred by the prospect of mutilating surgery, to get their breasts checked for cancer.

Some implants leak, usually small quantities of silicone. There isn't any good evidence that small amounts of silicone are dangerous to the body. Silicone is used in other implants, such as joint replacements, the Norplant contraceptive, and testicular implants, with no signs of any ill effects. Also, diabetics who use silicone-coated needles every day absorb a great deal over the course of a lifetime.

In rarer instances, breast implants may rupture. This poses a risk of infection and requires surgery to remove the implant.

Those are the documented risks. There are also a lot of undocumented ones, which implant opponents use to scare regulators and win lawsuits. The main scare story is that implants can cause autoimmune diseases—a claim for which there is no epidemiological evidence. (Silicone, like other foreign subtances, can trigger antibodies, but that reaction is not the same thing at all.)

Nightline, for instance, featured a woman who had had an implant and later developed sclerodoma, a rare connective-tissue disease that causes a painful tightening of the skin over the bones. The reporter said the woman's doctor "believes the disease was caused by silicone leaking from the breast implant." It's easy to understand why a doctor trying to explain a rare disease would settle on such an explanation. Looking at the big picture, however, there is no evidence that sclerodoma is any more common among breast-implant recipients than it is in the general population.

That's the evidence. Women (and a few pectorally conscious men) who receive silicone breast implants do take risks. The real question is, Should David Kessler, the head of the FDA, and his informal adviser Sidney Wolfe, the director of Public Citizen's Health Research Group, get to decide whether women can take those risks? There is a lot more at stake here than big breasts.

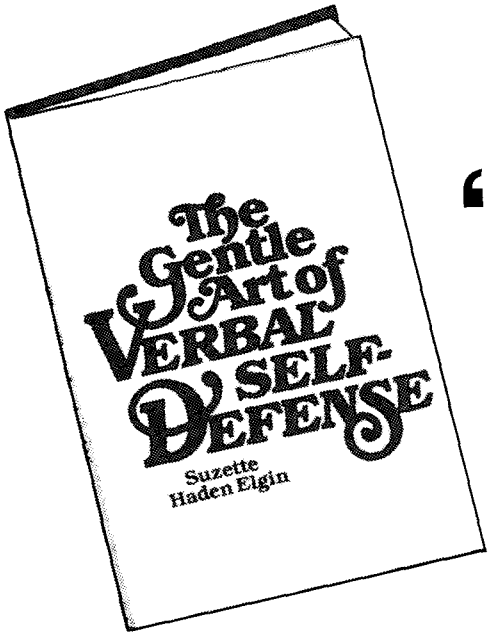
The core argument against the implants isn't that they're unsafe. It's that they're unnecessary. "Plain and simple, there is no public health need for these extremely unsafe devices to remain on the market. They are cosmetic devices for which far better alternatives exist," Wolfe said in a press release.

Consider the implications of that argument: Any "unnecessary" device that poses risks should be banned as long as "better" (that is, safer) alternatives exist. And political appointees will decree what's necessary and what's better, with help from puritanical pressure groups.

For women, the stakes are very high. Let's not even talk about abortion, where there is at least an arguable third party involved. Nobody "needs" the Pill. It presents health risks (although it may also have health benefits). Indeed, the Boston Women's Health Book Collective, a major opponent of breast implants, ranks the Pill below various forms of the rhythm method and below abstinence on its list of birth control methods. Applying Wolfe's criteria, the FDA would ban the Pill on the grounds that we can just use diaphragms and condoms.

On the same grounds, the FDA could ban tampons, which, like silicone breast implants, are medical devices that were already in use when Congress expanded the FDA's regulatory authority to encompass devices. Like implants, tampons are grandfathered at the FDA's discretion. They, too, are "unnecessary"—safer alternative technologies exist—and, unlike breast implants, they have been definitively linked with fatalities, caused by Toxic Shock Syndrome. What's more, tampons are currently under attack by some environmentalists and ecofeminists. Wolfe's "vital needs" approach has no logical stopping place, short of a Third World lifestyle.

If there is an argument for government regulation of drugs and medical devices, it is that regulation protects patients who don't have time to get the information they need to weigh risks and benefits. Like many medical arguments, this assumes that decisions are made in emer-



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About the Author

Psycholinguist Suzette Haden Elgin has presented her innovative self-defense principles in a variety of formats. She has given workshops and seminars all over the U.S., including verbal self-defense sessions for doctors, lawyers, and other professionals. Dr. Elgin has also created a self-defense tape and a training manual for people who teach her self-defense techniques.

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gencies and that the government-patient relationship is sounder than the doctor-patient relationship.

Now I am not a great truster of doctors, so I understand the allure of bringing a third party in as a protector. But history is full of once-independent countries who asked budding empires to protect them from their enemies—only to wind up as colonies. And Kessler's FDA is looking more imperial every day.

Most breast implants are, in fact, used for purely cosmetic reasons; 80 percent of the women who get them just want larger or firmer breasts (of course, reconstructive surgery is also cosmetic). This makes implants easier to attack politically, especially since East Coast intellectuals tend to consider all cosmetic surgery bizarre.

But the very frivolity of implants argues *against* regulation. Cosmetic-surgery patients have plenty of time to shop around, to do research, even to call up Public Citizen and hear warnings of doom. They can be as fully informed as they want to be. Then, if they proceed to spend their own money—insurance doesn't cover these things—on their own bodies, it's hard to say how the "public interest" is involved in any way.

Breast implants may make for tabloid television, but they're as important as any medical issue facing policy makers. They raise a far more basic question than how to trim a few dollars off Medicare spending: Who owns your body—you, or David Kessler? Before we embark on health-care reform, or make major breakthroughs in genetic engineering, we might want to think about that question.

NO GUARANTEES

JACOB SULLUM

When George Bush threw up at a state dinner in Tokyo last January, he inadvertently expressed the appropriate response to the special pleadings of America's Big Three automakers. Unfortunately, it was Japanese Prime Minister Kiichi Miyazawa, rather than Chrysler chairman Lee Iacocca, who bore the brunt of the president's nausea.

Though a public-relations disaster, Bush's trip, by highlighting the hypocrisy of Iacocca et al., may yet have a positive impact on trade policy. It's difficult to see how anyone who followed the story could have failed to see the mendacity of these self-proclaimed free-trade advocates: We're not protectionists, they said, but we may not be able to stop Congress from slapping more tariffs on Japanese imports unless trade relations improve.

There is room for improvement. Like the United States, Japan maintains various trade barriers, including some in the auto industry. But the sort of improvement the Big Three have in mind is evident from their response to Japanese concessions.

Among other things, the Japanese government agreed to offer low-interest loans and tax incentives to U.S. firms doing business in Japan. Japanese car companies said they would buy more foreign-made auto parts and try to double the number of U.S. cars sold in Japan each year. American automakers objected not to the nature of these commitments but to their size. They like the idea of special assistance and guaranteed sales.

You might think that the Big Three would be embarrassed by the implication of this approach—that American manufacturers cannot compete without affirmative action. But like arrogant beggars, the heads of America's car companies consider a handout a matter of right rather than charity. "We didn't ask them to make concessions," insisted G.M. chairman Robert C. Stempel. "We're not asking that they give us anything. We're just asking to compete."

Of course, they're asking for much more than that: They're asking—really, demanding—to compete without risk. When asked why they don't open manufacturing plants in Japan, why they don't set up their own distribution systems, why until recently they couldn't even produce a car with the steering wheel on the right side to accommodate Japanese drivers, U.S. automakers always give the same response: Too risky. We can't make those kinds of investments until we have enough sales volume to justify them.

"It would be nice to have factories here, but you go where you are wanted," Iaccoca said. "Obviously, if the market really starts to grow, you would like your own distribution system," Stempel said, "but we are not considering that now."

Japanese automakers think their U.S. counterparts have it exactly backwards: You build sales by making investments up front, by adapting your product to the new market, by taking a chance. The evidence suggests that this approach works. Such companies as Applied Materials, Schick, and Coca-Cola have pursued it successfully in Japan. And Japanese companies have used it to capture one-third of the U.S. car market. By contrast, American companies make less than 1 percent of the cars sold in Japan.

It's not credible to attribute this huge difference entirely to exclusionary trade practices, as the Big Three implicitly do. While some Japanese policies discourage private car ownership and raise the prices of foreign vehicles, they cannot account for the virtual absence of American cars from the Japanese marketplace. They certainly cannot explain why European carmakers are much more successful in Japan than their U.S. competitors, or why the Big Three are losing ground to the Japanese at home.

Indeed, complaints about Japanese protectionism from American carmakers are notably short on specifics. Taking a cue from U.S. civil-rights law, the Big Three prefer simply to assume that any statistical disparity is due to unfair discrimination. They try to justify this assumption, if at all, by citing the improved quality of American cars. But these speeches are aimed at politicians and policy makers rather than consumers. And that, in a nutshell, is the problem.

IN MEMORIAM:
MORTON B. JACKSON

Tony Jackson, a good friend and Reason Foundation board member, died December 10 at his home in Pacific Palisades, California. He was 70 years old.

By profession, Tony was an attorney, most recently with the international law firm of Baker & McKenzie. But in reality, Tony was a Renaissance man. For the past two decades he was passionately involved with the Los Angeles Chamber Orchestra and other music organizations. He was a board member of the Thomas Jefferson Research Center, which works with high school students on self-esteem and character education.

Tony's early career gave him a broad international background. After serving as a naval aviator in World War II (during which he received the Distinguished Flying Cross), he lived in Bangkok for three years in the 1950s working for an engineering firm, followed by four years in Geneva as assistant to the director of the Intergovernmental Commission for European Migration.

When he moved to Los Angeles in 1960 and joined a law firm, he also began an 18-year career in broadcasting. He hosted an award-winning weekly radio commentary program on KMPC, as well as a three-year weekly public affairs television program on KTLA.

Tony's long-standing commitment to freedom led him to subscribe to REASON, to become a supporter of the Reason Foundation, and, in 1988, to join the foundation's board. He was a superb board member. We will greatly miss his enthusiastic support.

—Robert W. Poole Jr.

IN MEMORIAM:
PHILLIP K. SALIN

One of the outstanding young thinkers of classical liberalism died December 12 in Redwood City, California, after a valiant battle with liver cancer.

Phil Salin, 41, was a UCLA graduate in economics with an MBA from Stanford. Some of his early work on telecommunications policy helped to lay the basis for the breakup of AT&T and the deregulation of this vital field.

In the 1980s he was a co-founder and first president of ARC Technologies, one of the first private space launch companies (and the first one to successfully launch its own rocket). His research (some of it sponsored and published by the Reason Foundation) on the cost of the space shuttle forced NASA to admit its true cost and helped lead to the Reagan administration's post-*Challenger* decision to abandon NASA's monopoly on launches.

More recently, Phil's interest turned to information and software services. He founded and was president of American Information Exchange (AMIX) Corp., a pioneering information-services company inspired in part by F. A. Hayek's idea of spontaneous order. AMIX is now a subsidiary of Autodesk Inc.

Phil Salin was one of a kind. We have lost one of this generation's finest minds as well as a warm, wonderful human being.

—Robert W. Poole Jr.

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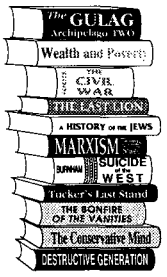

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LETTERS

A Tale of Two Governors

Rick Henderson leaps too quickly to make a superficial comparison between Gov. William Weld of Massachusetts and Gov. Pete Wilson of California ("Bigger or Better?", Nov.). The comparison—praising Weld for cutting spending and damning Wilson for raising taxes—is at least a little misleading.

Gov. Weld has done a solid job in trimming spending and holding the line on taxes. But Gov. Wilson has also done a good job of dealing with problems that, in fact, dwarf those confronting the governor of the Bay State.

Wilson inherited a $14.3-billion state budget gap—the largest in American history, bigger than the entire budget of Massachusetts. And while Weld could cut eight years' worth of fat accumulated under Michael Dukakis, Pete Wilson took the reins from another fiscal conservative, George Deukmejian.

California's changing demographics confronted Wilson with a rapidly growing demand for state services. California grew by 6 million people in the 1980s—as if the entire state of Massachusetts packed its bags and plopped down in the Golden State. Every year California has to build schools for an additional 250,000 students—a population the size of the entire Nebraska public school system.

When the budget gap doubled to $14.3 billion, no one offered an alternative to raising at least some taxes, because no one reasonably could. Wilson said repeatedly he could have closed down all state universities, emptied the prisons, eliminated all aid to the elderly, blind and disabled, fired all state employees, and still had a deep budget gap.

The bulk of California's new revenues come from a tax on consumption—the sales tax, the one tax least harmful to investment and job creation. And one-third of that hike is temporary.

Wilson did achieve several major reforms in the budget. He reduced welfare grants, froze them for five years, and reformed the system by raising earnings limits and encouraging welfare recipients to get off the dole and on the job. He also reduced the state work force, is attempting to trim state employee salaries by 5 percent, and began reforming the workers' compensation system.

He also cut the bureaucracy and red tape of government by realigning $2.3 billion in health and social services from the state to the counties. Also, he's establishing a Little Grace Commission to help him find other areas of the budget to cut, reorganize, or privatize.

Wilson has been a fiscal conservative over the years, drawing praise from Howard Jarvis and taxpayer groups. This year he faced down the toughest economic challenge conceivable. All of your readers should take the opportunity to advise the governor's Little Grace Commission on ways to make California government more efficient. I know their support, assistance, and advice would be welcomed by the governor and be beneficial to California.

Kirk West
President
California Chamber of Commerce
Sacramento, CA

WELD HAD THE EASIER JOB when it comes to finding fat to cut. Per-capita state spending following the respective budget agreements is $1,700 per person

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in California ($51 billion for 30 million people) and $2,150 per person in Massachusetts ($12.7 billion for 5.9 million people). Thus Weld will have to cut spending by another 20 percent just to reach Wilson's current level. If he eventually cuts spending by more than that, then he will definitely be Top Gov.

Daniel J. Ryan
Economics Department
Temple University Japan
Tokyo

LAST JUNE, AS THE legislature balked at his record-breaking tax increase, Pete Wilson warned, "Every day without a budget will cost Californians $11 million in lost revenues." Actually, those "lost revenues" were the additional sales taxes Wilson wanted to raise, but it has become an ironic figure for a different reason. Ninety days into the budget year, every day with Wilson's budget has cost taxpayers $11 million in additional red ink.

Measured against the administration's most optimistic revenue forecasts, California's budget was more than $1 billion in the red three months into the 1992 fiscal year; measured against the original budget, the deficit is closer to $2.6 billion. At the same point in last year's budget fiasco, red ink amounted to "only" $287 million.

During the budget debate, several legislators warned Wilson that his budget was on a collision course with economic disaster. Last June 28, on the floor of the Assembly, I said: "As sales decline, as layoffs increase, as small businesses which are barely holding on now are forced to close their doors—the revenue projections under this and other tax increases are bound to decline substantially, and we'll be back here, possibly by early spring, to deal with growing budget shortfalls."

We argued that instead of cutting the average family budget with more than $1,000 of new taxes, state government should do what millions of Californians were already doing: tighten its belt and live within its means. In April, I proposed some $27 billion of spending cuts—only half of which would have been necessary to avoid any new taxes. Unfortunately, the reforms were largely ignored, and those of us who had issued these repeated warnings were dismissed as "alarmists," "obstructionists," and "cavemen."

The worst is yet to come. Despite $8 billion of new taxes, from July to September actual receipts declined 0.6 percent. To keep up with revenue projections, in the final quarter of the current fiscal year revenue must grow by *26 percent.*

Tom McClintock
Assemblyman, 36th District
Sacramento, CA

Mr. Henderson replies: California's deficit was bigger than the Bay State's in dollars and as a percentage of the total budget. But in percentage terms, both were substantial: Massachusetts's budget was about 14 percent in the red; California's was 25 percent. Still, from his first days in office, William Weld cut taxes and spending. Pete Wilson started new spending programs virtually before the inauguration parade ended.

The eight years of "lean and mean management" by George Deukmejian produced the same illusory budget cuts we got from the two Reagan terms in Washington. State spending more than doubled under Deukmejian's watchful eye. Pete Wilson has been no more frugal. Spending went up by 10 percent in this year's budget. Wilson raised taxes by $8 billion to pay for $6 billion in new spending. And *The New Republic* reports that the state lost 100,000 manufacturing jobs from June 1990 to November of last year. During that time, state and local governments hired 50,000 more employees.

Mr. West's letter reminds me of the spanking scene in *Animal House*, in which the fraternity pledges drop their pants, grab their ankles, and each time the paddle strikes say, "Thank you sir, may I have another?" The serenity with which the state's business establishment has accepted, if not embraced, higher taxes and more stifling regulations from the Wilson administration amazes me. The California Chamber should pay attention to its supply-side-oriented colleagues at the U.S. Chamber in Washington.

Mr. West's letter also follows a recurring pattern among Wilson's defenders: Make believe no one presented an alternative to tax increases. Assemblyman McClintock and his fellow "cavemen" had ideas on the table; the big spenders in the administration didn't want to consider them.

Professor Ryan correctly points out that government spending is higher per capita in Massachusetts than in California. Far from being an endorsement of either Wilson or Weld, this merely indicates there is plenty of cutting for both governors to do.

Recovery Program

As a 15-year veteran of Alcoholics Anonymous, I feel I should comment on the characterization of A.A. members as "12-step evangelists" ("A.A. Abuse," Nov.). Some new members are evangelistic, but this is not uncommon among new members of any organization, especially one which people feel has saved their lives. Most believe in the slogan "attraction, not promotion." I have been to hundreds of meetings in a dozen cities and have never witnessed coercion or evangelism. A.A. is open to all who want to help and excludes no one, but runs no membership drives.

The article argues that, increasingly, courts violate people's rights by "sentencing" them to attend A.A. meetings. But this policy also causes problems for A.A. groups, whose members are simply trying to stay sober.

Many of my friends in A.A. disapprove of this judicial coercion, but what can we do? By our own canons, we cannot turn anyone away. If a person wants to attend an A.A. meeting, he or she is welcome—even when these persons are "sentencees" who make it quite clear that they are there under coercion.

Even if the national A.A. has a policy forbidding members there under judicial coercion, an A.A. group can ignore the policy. Any member who disagrees with one group can form another one. Short of disrupting a meeting, members are free to do whatever they please. A.A. is the most libertarian organization I have ever en-

countered.

The government has once again placed decent people in a dilemma. Our compassion wars with our principles. We ask for no funds nor any support from anyone. But the state will not leave us alone.

Name Withheld by Request
Three Oaks, MI

HAVING REALIZED MORE than 23 years of continuous sobriety as a member of Alcoholics Anonymous, I take exception to many of the points in "A.A. Abuse." Some of these arguments misstate the principles stated in the book *Alcoholics Anonymous*.

For example, the article states that "A.A. treatment is a process of spiritual conversion that *requires* submission to a 'higher power' (a.k.a. God)." The third tradition of A.A. says, "The only *requirement* for A.A. membership is a desire to stop drinking." The "a.k.a. God" should instead read "s.k.a. (sometimes known as) God." Some of us are atheists.

The article's contention that people are forced into A.A. is completely alien to the principles of the organization. When your article says, "The A.A. model, which uses a spiritual approach to treat the 'disease' of alcoholism, would not have as pervasive an influence under conditions of free choice," whose model is this? Nowhere in the steps or traditions of A.A. is force suggested nor is alcoholism defined as a disease.

Marty Mann and others who use A.A. to promote themselves do not abide by the eighth tradition, which suggests that "A.A. should remain forever nonprofessional. We define professionalism as the occupation of counseling alcoholics for fees or hire." Nor do they abide by the 11th tradition, which suggests that "we need always maintain personal anonymity at the level of press, radio and films." The "self-righteous," the "evangelists," the "counselors" are individuals, not A.A. itself.

Nyal A.
Sacramento, CA

ARCHIE BRODSKY AND Stanton Peele did an excellent report with some fine recommendations. But there were a few flaws. Among them:

1) Alcoholics Anonymous is involved in none of the abuses listed.

2) There is no such thing as "A.A. treatment."

3) A.A. does not endorse, finance, or lend its name to the National Council on Alcoholism, or any outside enterprise, including treatment programs.The fact that these organizations lend their names to A.A. is not a fault of A.A. or its members.

The authors have unfortunately accepted the illusion that A.A. is in some way akin to those many government and private entrepreneurs who have parasitically attached themselves to Alcoholics Anonymous. A.A. is successful because it is not allied with any other organization, has no governing authorities, accepts no outside donations, and guarantees that you can come and go anonymously. No one has the right to report to someone else that you've been to a meeting.

Several of us A.A. long-timers have a standing offer: If you come to A.A. from a court or an institution and you need a signature to verify your attendance, we will sign for you. And we will provide all the signatures you need for the duration of your "treatment." You need not attend the meeting. You only "have" to come back if you wish to do so under A.A.'s third tradition: a desire to stop drinking.

George K.
Des Moines, IA

THERE IS NOTHING WRONG with A.A., but there is definitely something awry with the people who repackage the A.A. program in greedy, for-profit treatment programs, and something is wrong with the people who view those programs as a cure-all for the suffering alcoholic.

Our society seeks quick-fix solutions to problems such as alcoholism. We look at an individual with problems and, if he or she drinks at all, we label that person an alcoholic. We then try to fix that person, often forcibly, to "get them out of our hair." Then we can smugly go about our business, secure in the knowledge that we have done our part.

I am a recovering alcoholic with a fair amount of sobriety under my belt. I knew I had a problem with alcohol. I tried everything—religion, *est*, T.M., psychologists, hospitalization, Rolfing, exercise, voluntary treatment. Then I was forced into treatment by relatives and later by the courts. You know what? I still drank. None of the quick fixes worked!

Often I am asked to chair an A.A. meeting. I go through the usual introductory material, then ask, "Are there any court-appointed people who would really rather be somewhere else? If so, bring up your slip, I'll sign it, and you can be on your way."

I'm only speaking for myself, but I say to the courts: Stop sending people to A.A. We don't want them. They disrupt our meetings. They're royal pains. We don't want anybody who doesn't want to be there!

The 12 steps of A.A. offer a program of living that everybody, alcoholics and nonalcoholics alike, could use. They tell us to take responsibility for our own lives and to stop blaming others for our plight; when we are wrong or have wronged someone to promptly admit it; to be honest with ourselves and others; to stop taking life so seriously and feel we are the center of the universe; that we simply have to do our best and let go of the rest.

There is nothing wrong with A.A.

Dwight E.
Grand Junction, CO

"A.A. ABUSE" ARGUES that judges are ordering people into A.A. or into treatment centers at an increasing rate. What alternative does the court system have? It can sentence repeat offenders to prison—that institution run by criminologists and psychologists. Prison keeps some offenders off the streets for a while, but even that is questionable punishment for an alcohol or drug offender. Most likely, this person will come out with an education in criminal techniques and a resentment at society for what "it" did to him.

A Schick hospital in Fort Worth operated on a secular scientific medical model of treatment. It advertised a 10-day treatment plan "with a couple of two-day follow-ups."

Their method of treatment gave the patient a drug which produced violent

reactions, including vomiting, every time he ingested alcohol. Then the staff gave the patient his favorite drink.

This method is called aversion therapy. It is a classical psychologist's dream. No faith in a "higher power" is involved. No dependence on group support. No mention of God. Just straight, secular psychological science.

Well, that hospital is out of business, while those treatment centers based on the A.A. model are thriving. The thousands of newcomers coming to A.A. through the courts and the treatment centers are coming because A.A. works. I believe Mr. Brodsky and Dr. Peele would have nothing but praise for a judge who sentenced drug and alcohol offenders to the psychiatrist's couch.

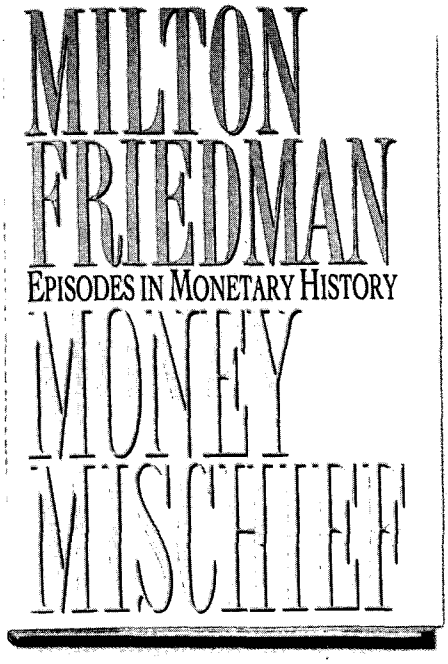
Psychologists, psychiatrists, and counselors are licensed and regulated by the state. It is amazing how some would rather send those in need of help to licensed, regulated professionals whose methods get poor results rather than an unregulated, private fellowship whose methods get amazing results.

James W. Byrd
Flower Mound, TX

Mr. Brodsky and Dr. Peele reply: We have no quarrel with those who choose to go to A.A., and we accept the personal validity of their belief that A.A. has helped them. We also sympathize with A.A. members' objections to the imposition of coerced clients on their voluntary organization. Signing people's cards whether or not they attend is a reasonable response to this imposition, but it would be better to inform the court that it is against A.A.'s traditions to participate in coercion.

Although many in A.A. subscribe to its voluntaristic traditions, it is an oversimplification to set A.A. apart from the (in George K.'s words) "government and private entrepreneurs who have parasitically attached themselves" to it. Many of these true believers who coerce people into A.A. are themselves involved in A.A., and their fanaticism is fed by the self-righteous, conformist atmosphere of some A.A. meetings, as described firsthand in sociologist David Rudy's book *Becoming Alcoholic*.

James Byrd's complacent assumption that A.A. and A.A.-based treatment get good results is unwarranted. Such claims, based on unrepresentative personal testimonials, are refuted by comparative research. Mr. Byrd is equally wrong to infer that we support court-mandated psychiatric treatment. Our recommendations emphasized practical skills training, not psychotherapy. And our article stated clearly that society's role is to hold people accountable for unlawful behavior, not to dictate specific treatments. We focused on mandated A.A. attendance because the violation of religious freedom is especially egregious. Whatever the merits of prison vs. other sanctions, the courts are the appropriate place to deal with criminal behavior, which includes reckless driving, let alone the violence perpetrated by the amoral "killer drunk."



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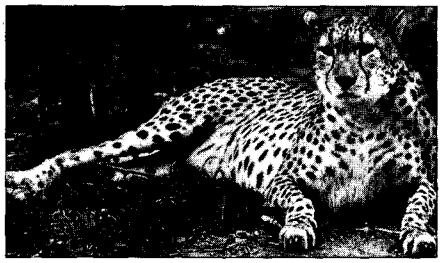
Animal Pragmatism

What do you do with a homeless peacock? Zookeepers had to deal with such problems when the Petting Zoo in Manhattan's Central Park closed last year because of New York City's budget problems. Most of the petting zoo's inhabitants found new homes with local families. Fortunately for both zoo animals and the children who visit them, many cities are privatizing their zoos rather than letting the gates close for good.

Cities with private zoos include Fort Worth, New Orleans, Cincinnati, San Diego, Knoxville, and Jackson, Mississippi. Many others—among them, Boston, Pittsburgh, and Birmingham, Alabama—are considering privatization because of budgetary problems.

Some zoos develop co-management/ownership arrangements between government officials and private, nonprofit zoological societies. Dual administration has its pitfalls, though: The much-publicized power struggles between the Greater Los Angeles Zoo Association and the L.A. Recreation and Parks Commission resulted in the resignation last November of the association's president, Bruce Nasby, who had raised paid association memberships from 80,000 to some 135,000 during his 3½-year tenure. The lion's share of the responsibility for running the L.A. Zoo has returned to the city government.

The Philadelphia Zoo, private since it opened in 1874, is frequently lauded as an example for other cities. The Zoological Society of Philadelphia augments the $10 million generated by admission and membership fees with corporate sponsorships and fund-raising activities such as the "Run Wild at the Zoo" 10K road race, the Ben Franklin Look-Alike Contest, and the annual Zoobilee! party. The zoo's 1991 budget topped $14 million—not a penny of it from government coffers.



The United States isn't the only country with private zoos. Forced to kill their goats and cows so the carnivores wouldn't starve, officials in Buenos Aires decided to turn their century-old zoo over to a private owner last year. With private capital and admission revenue, the zoo was able to acquire over 800 new animals in a matter of months.

Director Juan Romero summed up the secret of his success in *The San Diego Union*: "It is faster to obtain money as a private organization. As a state operation, it would take two years to get new uniforms for the caretakers; now we have one meeting and we get what we need."

—Elizabeth Larson

Unnatural Monopoly

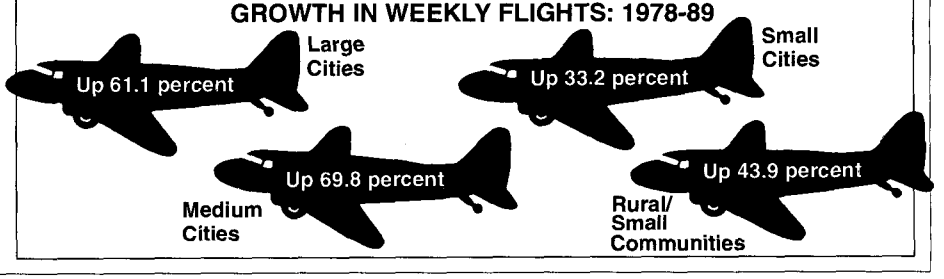
For a long time, introductory economics textbooks taught that telephone service was a "natural monopoly." After the breakup of Ma Bell, competition among long-distance carriers became commonplace, but the assumption that local telephone service was destined to be a monopoly lingered. The competition emerging from a combination of deregulation and new technologies suggests that this assumption may also be mistaken.

New competitors are beginning or planning to offer local phone service at cheaper prices, in more-convenient forms, and in better-tailored packages. For example, Chicago-based Metropolitan Fiber Systems operates fiber-optic telephone networks in 12 cities nationwide, connecting businesses in 850 buildings to each other and to long-distance carriers. In New York, the company recently started connecting its customers to

Plane Truth

Airline deregulation has saved travelers big money—$15 billion a year, according to a Brookings Institution estimate. But it has also led to increased service, even to small cities. In part, this is because the hub-and-spoke systems developed after deregulation connect travelers from small and medium-sized communities to hubs, from which they can travel to a wider variety of destinations.

In the new journal *Domestic Affairs*, transportation economist Elizabeth E. Bailey of Carnegie Mellon University reports that the number of flights has increased dramatically since deregulation. Her figures include 28 large cities, 29 medium-sized cities, 58 small cities, and 382 rural or small communities.



businesses off its network, via NYNEX lines. It plans to offer similar service in Boston and other cities.

Metropolitan Fiber has applied to the Illinois Commerce Commission for permission to offer direct dial-tone service to its customers, who currently use dedicated lines. It would charge businesses for transporting calls to Illinois Bell's central switching office and for additional services such as call forwarding, at rates lower than those offered by Illinois Bell.

Meanwhile, McCaw Cellular, the nation's largest mobile-phone company, and Tele-Communications Inc., a major cable-TV firm, are testing a wireless telephone service for residential customers. The system, in experimental use in Oregon, bypasses the local phone company by using McCaw's cellular phone network and TCI's fiber-optic TV cables. Customers communicate with small, hand-held sets that are more portable than conventional cordless phones.

AT&T is planning to experiment with pocket phones that would be linked by its nationwide network of 3,000 microwave towers. After making sure that the system won't interfere with existing equipment, the company expects to distribute the radiophones to test groups of 1,000 people each in Boston, Atlanta, and Los Angeles by 1993.

Although local phone companies do not relish the prospect of competition, deregulation offers them a consolation prize. Last fall, a federal appeals court ruled that the Baby Bells may offer their own news and information services, in competition with some of the same companies that will soon be trying to grab a share of their telephone business.

—Jacob Sullum

"The point is not that plundering the rich is immoral, but that it doesn't pay, doesn't reduce but increases inequality..."

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BALANCE SHEET

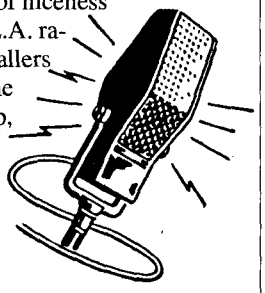
Assets

The End. The Soviet Union is dead. Happy New Year.

Nervous Take. The Supreme Court agrees to hear five property-rights cases, all aimed at a more vigilant reading of the Takings Clause. Civil libertarians squirm. Noted hypocrisy-buster Michael Kinsley says property rights are at greater risk than free speech. He says the Takings Clause protects them. Then he says he doesn't care: "My liberal heart does not bleed much for the 'victims' of democratically enacted government regulations."

Plane Dealer. McDonnell-Douglas spares taxpayers a Lockheed-style bailout. Selling 40 percent of its commercial aircraft business to Taiwan Aerospace taints the struggling company with the "foreign" label, making handouts a political impossibility. Taiwan Aerospace president Denny Ko is bullish on California as a center for his company's brainwork—technology, marketing, and design—and for future Chinese investment.

Free Waves. EEOC chairman Evan Kemp defies the politics of niceness to defend free discussion. The severely disabled Kemp says an L.A. radio station had every right to air a talk show in which host and callers argued that a local anchorwoman shouldn't have kids because she has a genetically carried disability. Such notions hurt, says Kemp, but the disabled can compete in the marketplace of ideas. They aren't served by censorship.



Liabilities

Veiled Future. Algerian voters give the Islamic Salvation Front control of parliament, promising an Iranian-style future. Algeria's women look forward to Mr. Kinsley's "democratically enacted government regulations." A businesswoman tells the L.A. *Times,* "We can either leave...or we can pray and pray and pray that the army takes over."

Chemical Reactionary. "Pollution prevention" goes mainstream. Rather than avoid harm to the public, the argument runs, we should ban any evil chemical, no matter how well controlled. Barry Commoner promulgated this notion in *Greenpeace* a few years back. Now EPA chief William Reilly pushes it. For a guy who came in fifth for president (behind Reagan, Carter, Anderson, and Clark), Commoner sure knows how to make appointments.

Auto-Crat. Bush's tough-talking trade trip to Japan spotlights the Big Three CEOs—the same geniuses who for years wouldn't make a right-hand drive car for the Japanese market. (Imagine how many Jaguars the Brits would sell here if the steering wheel were on the right.) Big successes with marketing savvy, notably Toys 'R' Us, merit only photo ops.

Lemon Torts. Despite Quayle's campaign for reform, the liability system gets worse and worse. In suit-happy California, the state Supreme Court loosens the standard for establishing negligence. And in Minneapolis, a U.S. district court rules that sexual-harassment suits can be filed as class actions rather than individual complaints—making them more lucrative, and enticing, for plaintiffs and lawyers.

—Virginia I. Postrel

Cornrow Row

For 12 years Cornrows & Co. has offered braiding, weaving, and natural hair care in the 4,000-year-old African tradition to women in Washington, D.C. Now the D.C. Board of Cosmetology wants to close the salon for violating district licensing laws. Enacted in 1938, when blacks weren't even allowed in beauty parlors, the laws require proficiency in finger waves and other outmoded hairstyles but ignore the nonchemical hair care now popular among African-American women.

With the help of the Washington-based Institute for Justice, Cornrows & Co. is fighting these rules as a violation of the Fifth Amendment and the Civil Rights Act of 1871. The outcome of the case could set a precedent for challenging licensing laws on constitutional grounds.

The cosmetology board has been hounding Cornrows & Co. because its employees are not licensed cosmetologists. In 1989, it slapped owners Taalib-Din Uqdah and Pamela Ferrell with $1,000 in fines for operating a beauty salon and training program without a license.

Last fall, after the D.C. Board of Appeals upheld the fines, the Institute for Justice filed suit in federal court against the cosmetology board and the District of Columbia on behalf of Uqdah and Ferrell. The suit argues that "the arbitrary diminution of plaintiffs' economic liberty by the imposition of these regulations deprives them of due process of law."

Rather than have prospective employees spend as much as $5,000 for a nine-month training program that wouldn't even teach them how to comb African hair, Uqdah and Ferrell train their braiders themselves in a three-month program that costs $2,400. Cornrows & Co. has trained hundreds of unskilled and unemployed young people in the art of African hairstyling.

"There's obviously a double standard going on here," Uqdah told *The Capital Spotlight.* "They're willing to take my $30,000 in taxes, but somehow I'm illegal. They're there to protect their own."

—Elizabeth Larson

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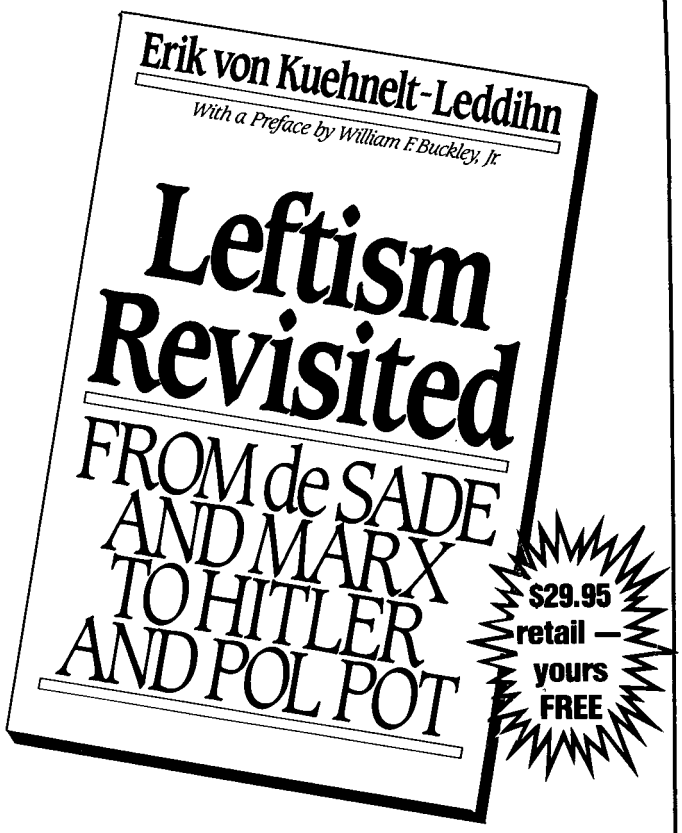
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"Communism isn't the enemy," observed Malcolm Muggeridge. "Liberalism is the enemy."

When Muggeridge said that, Communism was riding high. Now Communism is in crisis, while liberalism continues to choke religion and civilization. Muggeridge saw the heart of the problem. Communism was an external threat; liberalism not only corrupts from within, but also masquerades as something good.

Erik von Kuehnelt-Leddihn is of the same mind. He sets his sights on the Left *in all its manifestations*. He's been doing that for 60 years. The range of his reading, his travel, his vision carries him across the globe, and across the centuries. The world is truly his oyster.

And now, the new book that William Buckley rightly calls "his masterpiece." Adds conservative columnist Joseph Sobran: "I despair of doing justice to the book's wealth of oddly enlightening fact, the harvest of long experience, reading, and travel."

Precisely. Kuehnelt-Leddihn's view of the Left, in all its guises, is at once so particular and detailed, and at the same time so sweeping, that reading him is a unique experience, mind-opening. Max Eastman captured the feeling perfectly after reading one of his earlier books: "Amazing! Reading it is like going to college and graduate school all over again."

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BRICKBATS

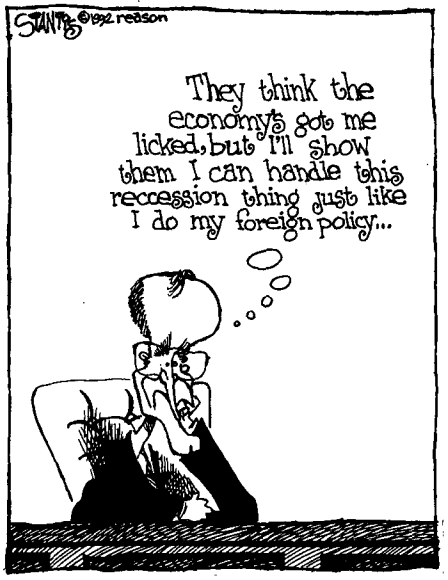
Police in Vista, California, burst into Mario Balcazar Suarez's home at 5:25 a.m. and ransacked the place looking for drugs. The raid was prompted by the arrest for drug possession of a former tenant. (The man's driver's license still showed his old address.) When told that Balcazar Suarez was upset by the treatment he received, a spokesman for the Vista police told the *Los Angeles Times*, "I don't think they have a complaint....We did do some damage...but the law allows us to break and enter."

The recent trial of S&L kingpin Charles Keating revealed that his company once spent $1,948 on Silly String for an office Christmas party.

The director of the upcoming *Lethal Weapon III*—the latest in the ultraviolent series featuring Danny Glover and Mel Gibson's butt—has decided against using General Motors automobiles in the film because G.M. uses animals in safety tests. The film presumably will instead depict the bloody deaths of dozens of Ford drivers.

And in Montana, Robert Redford has just wrapped up filming on *A River runs Through It*, a film about the joys of fly fishing. In deference to animal-rights activists, Redford did not actually catch any fish. The "fish" tugging on actors' lines were really plastic bottles half-filled with water and placed under surfaces of the streams. Stunt fish were used for closeups, but Humane Society officials were on hand to make sure the animals weren't traumatized by being handled.

In Telluride, Colorado, environmentalists protested the construction of a new golf course by burning diatribes against the owner into the greens with chemicals. Funny, I remember when environmentalists used to protest chemical spills, not make them.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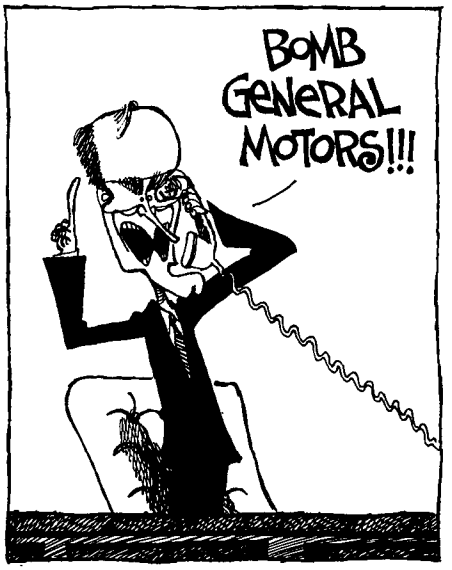

In Mobile, Alabama, a man has entered a conditional guilty plea to charges that he plotted to eliminate the Alabama red-bellied turtle from the wild. The man planned to get a federal grant to reintroduce the species.

In Kankakee, Illinois, a man was arrested for making a deposit at the bank. The man had two identical bags in his car when he pulled into the drive-in window. One contained money; the other, marijuana. He put the wrong one into the pneumatic tube.

A longtime REASON reader wants to thank the U.S. Postal Service for recently delivering his May 1985 issue.

Meanwhile, the Postal Service lost the entire shipment of the November issue of the New Hampshire Public Television programming guide. Viewers should get the guides around the middle of 1998.

Social workers in Canton, Ohio, took Raymond McIntosh's four daughters away from him because the girls had cavities. Charging McIntosh with abuse for neglecting his daughters' teeth, social workers returned the girls only after McIntosh produced their dental records, showing that they did indeed make regular visits to the dentist.

The musical group New Kids on the Block apparently has a friend in the Daytona Beach, Florida, sheriff's department. A deputy there arrested a motorist for violating state laws against obscene bumper stickers. The man's sticker read: NEW KIDS SUCK.

And in Palm Beach, Florida, the thong wars have taken a new twist. Longtime Brickbats readers will know that certain residents of that fair county have been trying to bar the lovely ladies operating sidewalk hotdog stands from wearing thong bikinis at work. County officials have given preliminary approval to a statute that will outlaw "G-strings, thongs, pasties, and socks." Socks, you ask? Lest you be alarmed that people with naked feet will be allowed to sell wieners, the law adds parenthetically "(For covering male genitalia)."

—Charles Oliver

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It's easy to see the logic in what Mr Day writes. At present the most common U.S. silver dollars are selling for about $12.50 each in rolls of 20 coins. Yet at less than $4.00 per coin, Canadian silver dollars offer greater rarity at a lower price.

The chart below compares current prices of the most common U.S. silver dollars with the Canadian silver dollar.

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POLITICAL PRESCRIPTIONS

NEITHER THE REPUBLICANS NOR THE DEMOCRATS ARE SERIOUS ABOUT HEALTH-CARE REFORM.

All eyes were on Pennsylvania last November, when Democrat Harris Wofford's come-from-behind victory over Republican Richard Thornburgh in a U.S. Senate race provided the only interesting landmark in a desolate off-year election landscape. But the gaze of politicians, reporters, and the public didn't rest for very long on Wofford or his much-hyped health-care theme.

If the truth be told, Wofford's "health- care proposal" was less a plan than a slogan: "If every criminal has the right to a lawyer, shouldn't every American have the right to a doctor?" That's great ad copy, but what does it really mean? Wofford apparently pictured some kind of nonprofit corpora-

BY JOHN HOOD

tion working with private insurers to keep health-care costs low while guaranteeing coverage to everyone. But that's about as specific as it got. Would the nonprofit corporation be funded by the federal government? By new mandates on business? Wofford didn't say, but then again, Thornburgh didn't ask. Thornburgh—and the Bush administration officials who advised him—saw voter worries about health care more as a sign of distress about jobs and the economic downturn than as a clear signal about health-care policy. So they never thought to challenge Wofford on the issue itself.

HARRIS WOFFORD'S "HEALTH-CARE PROPOSAL" WAS LESS A PLAN THAN A SLOGAN: "IF EVERY CRIMINAL HAS THE RIGHT TO A LAWYER, SHOULDN'T EVERY AMERICAN HAVE THE RIGHT TO A DOCTOR?"

Democrats in the national party and in Congress couldn't have been giddier about the Wofford win. Health care was already their chosen issue for 1992. Back in the spring of 1991, leading Democratic pols such as Reps. Henry Waxman and Pete Stark of California and Sens. Edward Kennedy of Massachusetts and Jay Rockefeller of West Virginia called for their fellow congressional Democrats to pass a comprehensive health-care reform plan—preferably some kind of benefit mandate on employers—and then hang Bush in 1992 with his expected veto.

Inertia and ennui (plus concern by a few lawmakers about the budget deficit) stymied this plan for months, but the Wofford win reinvigorated it. In December, Senate Majority Leader George Mitchell of Maine, a primary sponsor of an employer-mandate reform bill, and eight other Senate Democrats organized public hearings in five cities across the country to call attention to health care. "We cannot—we must not—sit back and wait for a consensus to emerge on how to solve this crisis," Mitchell yelped. In the House, 200 members planned public meetings in their districts on the same day, January 14. In New Hampshire, the Democratic presidential candidates held a December bluster-in, officially called a debate, to blast Bush for inaction.

The Democrats are right. The Bush team not only doesn't have a radical reform plan but is steering clear of anyone who does. "This is one issue where [Democrats] can convincingly claim that the president isn't doing anything," says Lisa Sprague, manager of employee benefits policy at the U.S. Chamber of Commerce. The Democrats, however, are no more willing to endorse systemic changes. That's why employer mandates, or even smaller changes involving state regulation and medical malpractice, dominate the congressional debate. The incentive for politicians during the coming election year is to talk a good game but to stay off the playing field.

KERI ROSEBRAUGH

The only two true reforms of the health-care system—national health insurance and consumer-oriented "managed competition"—would require radical changes in the way patients pay for health care and medical personnel provide it. They'd also cost money. That's why the storm clouds will continue to gather over health care in America, with politicians and opinion leaders thundering loudly about the need to reform but refusing, in the end, to bring the discussion down to earth.

The national debate over what to do about health care has advanced further than the Wofford "plan," but not by much. There are three main ideas under discussion—national health insurance, employer mandates (sometimes called "pay or play"), and managed competition—plus a fourth category, piecemeal reforms, where the action really is for now.

NATIONAL HEALTH INSURANCE

Except for the stray union lobbyist, Naderite activists, and Democratic presidential candidate Tom Harkin, there aren't many people actively promoting national insurance. In Congress, Rep. John Dingell (D-Mich.) heads the short list of players favoring it. Other members, such as Stark and Sen. Bob Kerrey of Nebraska (another presidential candidate), favor hybrids that retain some private insurers, employer payments, or diversity among states.

Maybe part of the problem is that national-insurance proponents are running out of countries—Britain, Sweden, Canada—to idolize, since each country's plan has shortcomings that become rather obvious when serious debate is joined. While the United States spends a lot more on health care than these "model" countries, Americans also have access to new technologies,

treatment innovations, and the latest surgical procedures. Countries with national insurance plans of some kind tend not to encourage much innovation.

Also, the goals of many national insurance plans are ideologically tinged and not directly related to improving access to medical care. "Any national insurance ends up being income redistribution," says Christopher Conover, an associate in research at Duke University's Center for Health Policy Research and Education, "even though that's better done by the tax system, if at all."

But the biggest factor scaring off potential supporters is the enormous price tag associated with moving America's $700-billion health-care industry from 40-percent government funding to the 90-percent-plus government funding a national insurance system would entail. Even if the much-vaunted cost savings of eliminating marketing, paperwork, and other "waste" materialize, American households will still have to pay about $2,000 apiece for the privilege of one-stop shopping for health-care coverage, notes Edmund Haislmaier, health-care policy analyst for the Heritage Foundation. National health insurance is an "internally consistent" position, he says, "but no one wants to pay for it."

NATIONAL HEALTH INSURANCE PROPONENTS ARE RUNNING OUT OF COUNTRIES—BRITAIN, SWEDEN, CANADA—TO IDOLIZE, SINCE EACH COUNTRY'S PLAN HAS OBVIOUS SHORTCOMINGS.

"PAY OR PLAY"

Despite its huge drawbacks, national health insurance—turning medical care into a closely regulated utility—does address the status quo's lack of accountability. Currently there is no link in the minds of patients between the medical care they purchase and its cost, and there is a limit to how much the cost-consciousness of third-party payers can substitute for that lacking in patients. This problem can be addressed in only two ways: by giving consumers more of a direct financial incentive to shop wisely for care or by taking choice away from consumers, as a nationally run health insurance system would.

The reform plan of choice among many congressional activists would do neither of these. The pay-or-play approach enshrined in Mitchell's bill, among others, would require employers either to buy health insurance coverage for their employees from private insurers (subject to federal mandates on the scope and type of coverage) or pay a new payroll tax to fund government insurance for those employees.

In practice, this system would probably collapse rather quickly into a Medicare-type federal insurance program for business employees. At first, employers would have a strong incentive to dump or avoid hiring workers whose health insurance would be costly. Recognizing that, Mitchell placed tough antidiscrimination language in his bill. But, as Heritage Foundation Director of Domestic and Economic Studies Stuart Butler told the Senate Labor and Human Resources Committee in 1991, "It is clear that attorneys would earn good fees from such provisions and that companies could face the prospect of potentially staggering damage claims from employees or would-be employees."

If the cost to "play" is this high, employers will choose to "pay," and more and more workers will move into the government insurance program—just as the combination of mandatory auto insurance and a subsidized assigned-risk pool lures increasing numbers of drivers out of the regular insurance market and into the pool.

Under pay or play, cost control will go out the window. This would get all the disadvantages of a national health insurance system without its one potential cost-control advantage. Furthermore, it would be funded by yet another regressive payroll tax, at a time when Social Security taxes are already reducing the real incomes of working Americans.

"I do not believe it is the intention of this committee or of Congress to fund America's health care system by taxing the poor," Butler said in his testimony. "Yet, that is precisely what [the Mitchell bill] would do."

Despite the obvious shortcomings of "pay or play," there are several political reasons why members of Congress, activists, and some business leaders are pushing it. In November, a coalition of CEOs of Fortune 500 companies, labor union reps, and consumerists called the National Leadership Coalition for Health Care Reform announced their support for an employer-mandate approach similar to Mitchell's bill. Big busi-

nesses, for one thing, already pay exorbitant health-care bills and want to make sure their smaller competitors have to as well.

There's an industry-sector dimension, too. "Many manufacturers want the service industry to pay their fair share," Sprague says. When uninsured employees need care, hospitals often provide it and simply shift the cost to paying customers in the form of higher prices. That drives up the cost of insurance for companies currently providing it. Meanwhile, union leaders, many of whom favor national health insurance but understand its political problems, correctly view pay or play as national insurance by stealth.

UNION LEADERS, MANY OF WHOM FAVOR NATIONAL HEALTH INSURANCE BUT UNDERSTAND ITS POLITICAL PROBLEMS, CORRECTLY VIEW "PAY OR PLAY" AS NATIONAL INSURANCE BY STEALTH.

MANAGED COMPETITION

The alternative proposed by Heritage, many health economists, and conservative lawmakers is to move away from employer-provided health insurance altogether, in favor of direct purchase of care by families. These reformers would end the current federal tax exemption for employer-provided care and replace it with a refundable tax credit for families to use to buy insurance, sign up with a health-maintenance organization, pay medical expenses out of pocket, or save for future medical expenses.

A bill introduced by Sen. Steve Symms (R-Idaho) probably comes closest to the ivory-tower vision of consumers shopping around for health care in a competitive, albeit managed, market. The Symms measure would do two things: 1) establish a refundable income-tax credit of 15 percent for most taxpayers, and between 50 percent and 100 percent for poor Americans, to pay for insurance or HMOs; and 2) create the Individual Medical Account (IMA), into which taxpayers could make annual contributions of up to $2,500 a year. Individuals could withdraw funds from their IMAs without tax penalty to pay for out-of-pocket expenses such as deductibles, co-payments, or other costs not covered by insurance. Up to $10,000 could be kept in an IMA without it showing up as gross income at tax time.

In conjunction with these changes, the bill would eliminate tax deductibility for employer-provided medical benefits. "Because we subsidize employer-provided care in the tax system, employers have an incentive to over-cover their employees," Duke University's Conover says. When providing a certain level of compensation to employees, businesses are encouraged by the tax code to pay relatively more in benefits and relatively less in salaries—even if the benefits aren't really needed. Making the tax system more neutral, so self-employed people get the same benefits as employees of large companies and everyone has an incentive to shop around for coverage (pocketing the savings generated by going to a less costly plan), would create a more competitive market for health-care coverage. That, advocates say, would spur insurers and HMOs to come up with more personalized packages tailored to different consumers, whose personal choices and physical health would become more important.

"A lot of health-care costs are lifestyle-related," notes Conover, but employer-provided coverage puts everyone in a big, undifferentiated pool. Groups of nonsmokers, married people, or others with demonstrably lower health risks could get better coverage at lower prices—but not in the current employer-driven system. Group insurance based around social organizations, unions, health clubs, churches, or other institutions would replace group insurance at the workplace. And since employment would be unrelated to coverage and the tax credit would be refundable, a large segment of the uninsured population—poor people without jobs or sufficient income to buy insurance—could obtain coverage.

There are some practical and political red flags here, however. First, consumers would suddenly be expected to shop around in a complex marketplace that was previously the domain of their employers. "It sounds kind of chaotic," says Sprague, though her organization, the U.S. Chamber of Commerce, and other lobbyists for small businesses favor this approach over pay or play. Would enough consumers have the knowledge and motivation necessary to make cost-effective decisions about their health care?

Perhaps, but the transition, at least, would

be pretty rocky. Some people with such incurable diseases as AIDS or with other special medical problems might have a hard time getting coverage (though competition advocates say insurers would have the incentive to develop ways to cover them) and would probably make a lot of noise about it. Lastly, some consumers could act as free-riders by choosing bare-bones plans, pocketing the savings, and then relying on the generosity of public hospitals when a serious health problem arises.

The political obstacles are even clearer. It's easier to put the onus on institutions, such as businesses or the government, than on individuals, especially during times of stress and rapid change. Opponents of the Symms bill or similar measures could use emotional appeals about "shifting responsibility from your employer to you." On the Hill, a health-care reform plan based on the tax system would have jurisdiction problems. The most activist members on health care sit on labor and human resources committees, not tax-writing panels, and they're likely to rely on measures they can pass and crow about, rather than going through the time-consuming and laborious process of putting together coalitions to make changes in the federal tax code.

PIECEMEAL REFORMS

That last reason is one motivating force behind what's really happening in health-care reform in Washington. Politicians are coming together to draft modest reforms with simple targets and low price tags that avoid major changes in the health-care finance system.

"People in the administration, and indeed most members of Congress, if they were honest about it they would admit they don't understand the issue," Haislmaier says. "So they either want it to go away or the next best thing—do as little as possible."

So, for example, Rep. Alex McMillan (R-N.C.), Sen. Pete Domenici (R-N.M.), and other members have introduced bills to reform medical malpractice. McMillan's bill would limit awards for pain and suffering and would require most Americans to settle cases outside of court. He would create a corps of professional arbitrators, adding to the current pool, to decide most cases.

Unfortunately, the savings from malpractice reform may not be very big. The actual cost of malpractice cases makes up only about 1 percent of America's health-care bill, according to consumerist groups. The out-of-pocket hidden cost of doctors performing "defensive medicine"—ordering tests or surgical procedures to avoid malpractice liability—is significantly higher but still isn't the main force driving the medical cost explosion.

MAKING THE TAX SYSTEM MORE NEUTRAL, SO THE SELF-EMPLOYED GET THE SAME BENEFITS AS EMPLOYEES, WOULD CREATE A MORE COMPETITIVE MARKET FOR HEALTH-CARE COVERAGE.

Other popular piecemeal reforms include measures to make insurance purchased by self-employed people tax-exempt and to preempt state mandates on insurance coverage that make it too expensive for small businesses. When the Bush administration finally announced its package of health-care reforms, promised for more than a year in December, it included small steps such as the establishment of a $3-billion program of school-based clinics and insurance for children, anti-smoking measures, and tort reforms. After an underwhelming response to those proposals, Bush finally embraced a modest, Heritage-like tax plan in his State of the Union address but did not endorse the sizable changes in the tax code needed to make the plan really work.

The trick for Democrats and Republicans alike is to sound like health-care reformers without doing anything rash or costly. Pay or play was the original product of this kind of thinking, but less drastic measures fit the bill even better. For Americans as a whole, this political dynamic is probably a blessing too, since the prospect of clueless lawmakers enacting a huge, pricey reform of the nation's entire health-care system should scare even the most trusting citizen. Advocates of a consumer-oriented system like the Symms plan say they are gaining ground among business and opinion leaders, lobbyists, and some members of Congress, so in the long term this approach may triumph. And in the short term, all the political rhetoric about 33 million uninsured Americans and spiraling health care costs and the like will remain full of sound and fury, signifying nothing—fortunately. ■

Contributing Editor John Hood is editor of Carolina Journal *and a columnist for* Spectator *(N.C.) magazine.*

MARKET MEDICINE

WE DON'T HAVE IT. BUT WE COULD.

"The shambles that is our health system proves incontrovertibly that care cannot be left to uncontrolled private enterprise," *The San Francisco Chronicle* editorialized last May.

"The American myth is that free markets and laissez-faire will take care of the health-care problem," Rep. Bob Wise (D-W.Va.) said at a press conference later that month. "It will not, and clearly that's been demonstrated."

Notwithstanding the casual assumptions of these and other reformers, the U.S. market in health care is not free, and the government's approach in this area is anything but laissez-faire. A myriad state and federal laws and regulations restrict who may provide what health-care services and

BY JACOB SULLUM

products to whom under what circumstances. Adult Americans are not free, by any stretch of the imagination, to purchase the health care they want from the providers they choose.

Indeed, for most Americans, a free market in health care is close to unthinkable. It would mean an end to the medical monopoly, to the licensing of health-care providers, to mandatory insurance coverage, even to the distinction between prescription and nonprescription drugs. It raises the specter of injury and death from brain surgery in the garage, inappropriate self-medication, and misplaced trust in the healing powers of magic crystals. But a free market in health care is worth thinking about nonetheless, if only because so many pundits are sure it could not possibly work.

EVERYONE SHOULD BE "FREE TO PRACTICE MEDICINE WITHOUT RESTRICTION," WROTE FRIEDMAN.

Three decades ago, in *Capitalism and Freedom*, Milton Friedman used the medical monopoly to illustrate the costs of occupational licensure. Although ostensibly intended to protect consumers from the unscrupulous and the incompetent, he wrote, licensure instead reduces choice, raises prices, and rewards a select few at the expense of their customers and potential competitors. He described how the American Medical Association, through the powers granted it by licensing laws, restricts entry into medicine, allowing its members to earn more than they could in a free market.

Friedman argued that "licensure has reduced both the quantity and quality of medical practice; that it has reduced the opportunities available to people who would like to be physicians, forcing them to pursue occupations they regard as less attractive; that it has forced the public to pay more for less satisfactory medical service, and that it has retarded technological development both in medicine itself and in the organization of medical practice. I conclude that licensure should be eliminated as a requirement for the practice of medicine." He recommended that anyone be "free to practice medicine without restriction except for legal and financial responsibility for any harm done to others through fraud and negligence."

Although Friedman's proposal remains controversial, research and practical experience during the last 30 years have bolstered the case for a free market in health care. One major source of waste cited by Friedman—the use of overtrained personnel to perform routine medical tasks—is today widely recognized. "Health care is a very labor-inefficient enterprise," says Arthur Caplan, director of the Center for Biomedical Ethics at the University of Minnesota. "You have highly trained people doing things that could be done by others."

To the extent that personnel are overqualified for the work they perform, consumers are paying more than they would in a free market. Say you have a dental appointment. You see the dentist for about 30 seconds. Most of your time is spent with the dental hygienist, who examines your gums and cleans your teeth. But you still have to pay for the dentist's training and overhead, so the visit costs $50 to $100. If dental hygienists were allowed to operate independently, the same service might cost half as much.

Ross Korves, an economist with the American Farm Bureau Federation, estimates that expenses for health-care professionals account for about 50 percent of the money spent on health care. Nearly 20 percent of the $604 billion spent in 1989 went to physicians. Labor expenses represented more than half of the $233 billion spent on hospital care.

There is reason to believe that much of this spending is unnecessary. For example, physician assistants, who generally undergo two years of training, can perform about 80 percent of the primary-care tasks that would otherwise be performed by physicians. These include taking medical histories, doing physical examinations, ordering lab tests, removing stitches, and advising patients about diagnosis and treatment. Salaries for physician assistants are one-quarter to one-third the salaries earned by doctors. A 1988 study published in *The Journal of Human Resources* concluded that physician assistants, first introduced in the late 1960s, are still underutilized in group practices.

Nurse practitioners—registered nurses with additional training—can fill the role of family doctors, providing basic health services at a lower price. A national survey conducted by the American Academy of Nurse Practitioners in 1988 found that, depending upon specialty, patients' first visits to nurse practitioners cost 12 percent to 45 percent less than

KERI ROSEBRAUGH

comparable visits to physicians. "They're an underutilized, untapped resource that could help reduce the cost of health care significantly," Caplan says. In particular, he suggests, nurse practitioners can serve rural and inner-city markets where physicians prefer not to practice. "N.P.s could do an excellent job at primary care in these areas. The only obstacle is that doctors want to exercise their monopoly power."

Nurse practitioners are hampered by laws that require physician supervision and limit their ability to prescribe drugs. Of the 33 states that give nurse practitioners some authority to prescribe, all but three require a doctor's input. Largely because of such restrictions, only 3 percent of nurse practitioners have independent practices. (Most work in hospitals, HMOs, clinics, or doctor's offices.)

Competition-conscious physicians are worried even by the limited success of nurse practitioners. As a recent story in *Medical World News* put it, "What unnerves organized medicine about all this is the specter of nurses in independent practice being paid directly for evaluating patients and deciding what action to take without consulting physicians. The AMA Board of Trustees, in a report at the 1990 annual meeting, detailed the warning signs of independent practice: direct reimbursement, prescription-writing privileges, and nursing students being trained in freestanding ambulatory clinics."

If nurse practitioners are setting off alarm bells at the AMA, they must be doing something right. The more worried the medical establishment, the greater the potential for consumer savings. For example, both nurse practitioners and physician assistants can play an important role in caring for the elderly and for patients with AIDS, two groups with chronic conditions that will be consuming growing shares of health-care spending in the next few decades. Physicians are attempting to stake a claim in this area, Caplan says, although M.D.s are inappropriate for such long-term care, which requires the ability to tend the day-to-day needs of homebound patients rather than extensive technical expertise.

In addition to nurse practitioners and physician assistants, M.D.s resist competition from osteopaths, podiatrists, chiropractors, optometrists, acupuncturists, midwives, and pharmacists—all of whom earn less money, on average, than physicians; all of whom can perform at least some of a physician's functions just as well or better; and all of whom are hobbled by protectionist legislation. For example, optometrists in many states may not prescribe eye drops, and in 24 states only physicians may perform acupuncture.

IF NURSE PRACTITIONERS ARE ALARMING THE AMA, THEY MUST BE DOING SOMETHING RIGHT.

One of the medical privileges most prized by health-care providers who try to compete with physicians is the authority to prescribe drugs. A free market in health care would mean not only that nonphysicians could prescribe to others but that adults would be free to prescribe for themselves as well. Until the late 1930s, in fact, Americans accepted self-medication as perfectly natural. Why go to the doctor if you can treat yourself?

In 1938, the head of the Food and Drug Administration emphasized that the pending Food, Drug, and Cosmetic Act was intended to assist, not prevent, self-medication. In practice, however, the FDA's regulations under the law cut consumers off from information about drugs and imposed mandatory prescription. The effects of this policy have been profound: Americans now assume that they need a doctor's permission to take a drug, unless the FDA decides otherwise. Hence the cost of a doctor's visit is automatically tacked on to the cost of obtaining any prescription drug. The price of the drug is also raised by the extra cost of dispensing it one package at a time rather than in bulk. And the prescription requirement may prevent the drug from reaching a wider market, which could reduce the price still further.

In a 1983 paper published in the *Journal of Health Economics*, MIT economist Peter Temin estimates the benefits of switching particular drugs from prescription to over-the-counter status. For topical hydrocortisone, which became available without prescription at the end of 1979, he estimates that the benefits exceeded the costs by more than $200 million in 1980 and more than $400 million in 1981. If penicillin were made available over the counter, he suggests, consumers could save on the order of $1 billion a year in doctor visits.

The examples I've cited so far suggest that a free market in health care has the potential to save consumers and insurers a lot of money. But could it work? One obstacle is third-party payment. Although employers shop for health plans and insurers try to keep a lid on costs, employees who receive free health-benefit plans rarely bear the cost of their health-care decisions. Consequently, they have little incentive to shop around or to forgo optional treatment. As long as the government taxes direct income but not health benefits, employees will prefer the former to the latter, and most Americans will continue to "purchase" health care without the benefit or discipline of price signals.

CAN YOU TRUST THE FREE MARKET TO DELIVER CORN FLAKES AND CAR WASHES, BUT NOT HEALTH CARE?

Another objection to a free market in health care is more fundamental. Many economists argue that health care is special. You can trust the free market to deliver corn flakes and car washes, they say, but not something as complicated and essential as health care.

In the 1970 book *Profession of Medicine*, sociologist Eliot Freidson put it this way: "If we believe that medicine possesses science and integrity markedly superior to competing occupations, we would not be inclined to invite the competition [Milton] Friedman calls for because of the suffering which could follow upon uninformed consumer choices in a truly free health care market."

This is not simply paternalism. For Freidson and like-minded academics, the "information problem" is not merely that consumers will err; it's that they generally will not know enough to make wise choices. Hence the market will not function properly. This claim is superficially plausible. After all, medicine is complicated. But is it uniquely so?

If we had to rely on our own expertise, we would make many purchasing decisions in the dark. On my own, I would be hard pressed to choose between radiation and surgery for the treatment of a tumor, or to decide whether to take penicillin for an infection. But I would also have no idea which computer to buy, or how to stop the knock in my car's engine. Consumers routinely rely on the advice of others to make decisions. They glean information from advertising, the press, sales people, competing businesses, consultants, referral services, friends, and relatives.

The current health-care system already requires consumers to choose doctors, select health plans, and consent to treatment. They do so with the help of books, second opinions, recommendations from acquaintances, and so on. Abolishing the medical monopoly would not close off these sources of information. Nor would it eliminate the credentials by which people judge health-care providers. You could still insist on being treated by an AMA-approved M.D. or a certified specialist. But you would also be free to select someone with different training—an osteopath, a chiropractor, a faith healer, an acupuncturist, a nurse practitioner—certified by a different professional association, or not certified at all. Furthermore, the demand for medical information would support new businesses aimed at helping consumers make health-care choices by offering laboratory tests, referrals, ratings of practitioners, and treatment track records.

Many people would probably rely on intermediaries—hospitals, insurers, health-maintenance organizations—to make sure that everyone treating them was competent. In 1962, Friedman envisioned department stores of medicine that would cost-effectively combine facilities, equipment, and personnel with various skills to provide health-care packages for a fixed fee. Health-maintenance organizations such as Kaiser Permanente are increasingly playing that role. In choosing a package, consumers rely on the name and reputation of the company, rather than investigating the qualifications of every employee or contractor.

A lack of adequate information is the major justification for the regulation of medicine. But it is also one of its main consequences. For example, the FDA forbids drug companies to tell consumers about most of their products. Similarly, a professional code enforced by the medical monopoly forbids doctors to advertise. Rather than make sure that consumers are fully informed, the law limits their ability to make intelligent choices, creating an artificial dependence on officially approved experts.

The potential benefits of health-care advertising are il-

lustrated by optometry. In a 1975 study published in *The Journal of Law and Economics*, Lee and Alexandra Benham found that prices for eyeglasses were 25 percent to 40 percent higher in markets with greater professional control over information, including restrictions on advertising, promotion, and location. In his 1980 study of optometry, *Professionalism and the Public Interest*, economist James Begun found that prices for optometric services in restricted markets were higher than could be justified by greater quality, even as defined by the optometrists. The Federal Trade Commission overturned state bans on the advertising of eyeglasses and contact lenses in 1979; by 1982 the average price of a pair of soft contact lenses had dropped by about $100 in real terms.

THE REAL PROBLEM WITH OUR SYSTEM IS THAT IT DOES NOT ALLOW ENOUGH VARIATION IN QUALITY.

If there really is an "information problem" in the healthcare market, current regulations only serve to make it worse. But health care is considered special not only because it is complex but also because it is important. In some ways, health care is a basic requirement of life, like food, clothing, and shelter. There's one crucial difference: It's relatively easy to define the minimum amount of food, shelter, and clothing that a person needs to survive. The need for health care, on the other hand, is potentially open-ended.

The expenditure necessary to keep someone alive varies tremendously depending upon the person's condition. The resources needed to stop a baby from dying of dysentery are nothing compared to the resources needed for a heart transplant to extend the life of a 65-year-old. Moreover, in addition to preserving life, health care may serve to improve one's faculties or relieve anxiety and discomfort. Are these also basic needs?

Health care is something we would like everyone to have, even if they can't afford it because their income is too low or the cost is too high. At the same time, it cannot be provided to everyone on demand in unlimited quantities. These constraints will prevail no matter how health care is organized. Whether we keep the current system, adopt a free market, or move toward socialized medicine, we will still have to deal with the question of how to provide health care to the poor or to those overwhelmed by catastrophic illness.

"It's much easier to turn away than to confront hard rationing decisions, to trust in the invisible hand and our tattered patchwork of support programs rather than in some new government bureaucracy," Public Citizen's Nancy Watzman wrote in *The Washington Monthly* last October. "Trouble is, the invisible hand isn't known for its compassion. As a result of the laissez-faire approach to medical care, we already have a rationing system in place—one based not on need but on ability to pay."

In addition to making the familiar but mistaken assumption that the United States has a free market in health care, Watzman confuses economics with philanthropy. By now there should be no question that rationing based on "ability to pay" (capitalism) is more efficient than rationing based on "need" (socialism). And the more efficient the system that provides health care, the more people will be able to afford it, and the easier it will be to provide for those who can't, whether through private charity or public assistance. The government can help people pay for health care without socialized medicine, just as it can help them pay for food without nationalizing supermarkets.

Activists like Watzman worry that the current health-care system favors the rich because it allows them to buy better health care than the poor. But the real problem with the system is that it does not allow *enough* variation in quality. As Friedman noted 30 years ago, doctors "look solely at technical standards of performance and argue in effect that we must have only first-rate physicians, even if this means that some people get no medical service." In his study of optometry, Begun calls this attitude the "quality-at-any-cost ethic of the professions," with quality defined, of course, by the professionals.

Most of the health-care reform plans being tossed around in Washington focus on cost control. But the key to cost control is quality control—specifically, the power to define the quality of health care and decide how much it's worth. Would-be reformers should consider the possibility that the customer may be right after all. ■

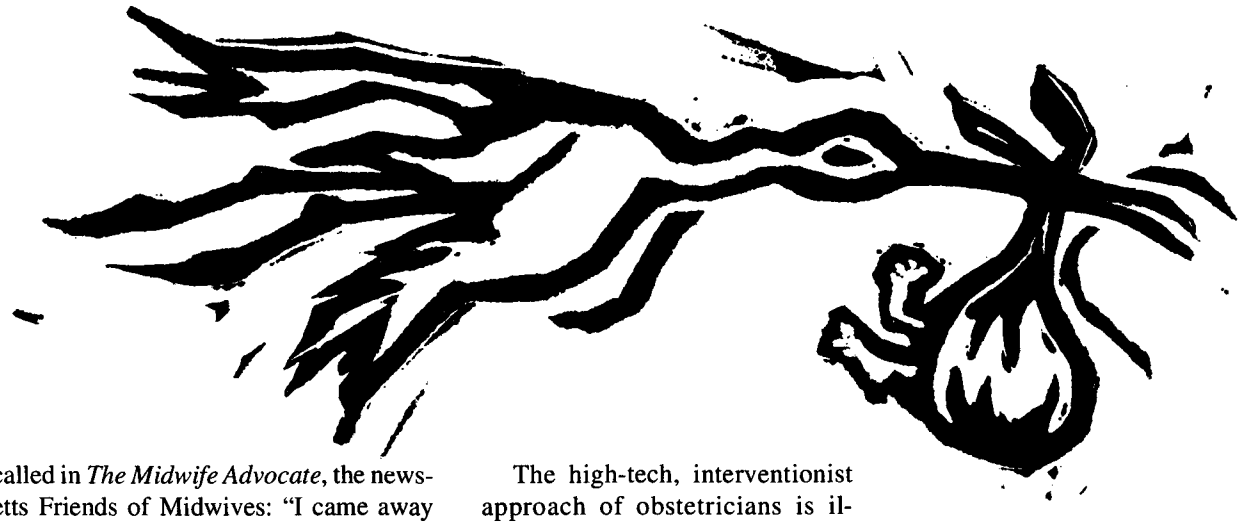
Jacob Sullum is associate editor of REASON.

HOME DELIVERY

MIDWIFERY WORKS. SO SHOULD MIDWIVES.

When Janet Podell became pregnant in 1989, she determined to have "the real thing"—the fully natural, satisfying birth experience that had eluded her when her first two children were born. Although midwives had assisted her in the two unmedicated births, the impersonality, tension, conflict, and pointless restrictions she experienced in the hospital had left her feeling frustrated and violated. Both times, for example, she was separated from the baby and from her husband after the birth. After moving to western Massachusetts, Podell found a pair of midwives to attend her birth at home. What resulted was a qualitatively different experience: She felt as if she had really given birth under her own power, in an atmosphere of loving support.

BY ARCHIE BRODSKY



As Podell later recalled in *The Midwife Advocate*, the newsletter of Massachusetts Friends of Midwives: "I came away from my hospital births with a sense of helplessness. I came away from my home birth feeling that I had learned deep and amazing lessons about my own strength and resilience, about trusting my body and my instincts....What would happen in this fearful society of ours if all the mothers who gave birth had such an experience?"

Podell is one of many American women who have chosen to give birth outside of a hospital during the last 10 to 15 years. Disillusioned with the routine intrusiveness of conventional hospital obstetrics, they have voted with their feet by giving birth at home with the help of family, friends, and supportive attendants. Some of these women, inspired by the rediscovery of birth as a natural and social event, have become midwives themselves, learning their trade by working with more experienced midwives or with sympathetic physicians.

This social movement, until recently marginalized by organized medicine as a softheaded countercultural rebellion, is now finding common ground with mainstream economic and public-health concerns: the rapid escalation of health-care costs; the loss of obstetricians resulting from the epidemic of malpractice suits; and the high rate of infant mortality among the inner-city poor. Midwifery works, people want it, and it provides an answer to some urgent policy questions. But although midwifery has made progress in recent years, a variety of laws and regulations still prevent midwives from offering their services to everyone who could benefit from them.

The advantages of midwifery depend on a more thoroughgoing change than just plugging in one type of practitioner in place of another. If the law confines midwives to the role of obstetrical handmaidens working exclusively in hospitals under the direction of physicians, it will prevent them from making their full contribution. For the word *midwifery* really stands for a fundamentally different model of maternity care: different people doing different things, often in a different place.

Midwives reject the view that giving birth is a medical procedure like having a gall bladder removed. Instead, they understand it as a natural process that ordinarily does not require drugs, surgery, or high-tech equipment. Obstetricians, whose skills and techniques are best reserved for complicated births, are in most cases not well prepared to attend normal births. They know how to intervene but not how to support without intervening.

KERI ROSEBRAUGH

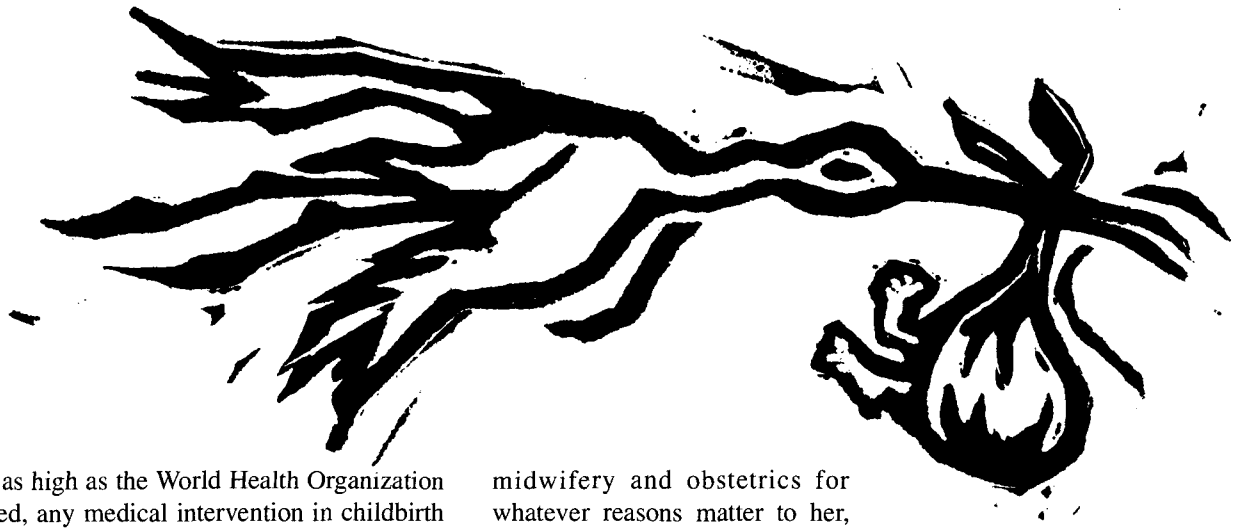
The high-tech, interventionist approach of obstetricians is illustrated by the widespread use of electronic fetal monitoring. EFM—which records fetal heart tones and the pressure of uterine contractions, either through electrodes passed through the birth canal and attached to the baby's scalp or through a transducer placed on the mother's abdomen—may have a legitimate rationale in high-risk births. But from the beginning it was marketed indiscriminately to physicians hungry for precise diagnostic information.

As a result, by the mid-1970s most U.S. hospitals had adopted EFM for routine use, without any controlled studies showing it to be more effective than traditional, noninvasive methods of listening to the baby's heart. Now studies published in the last two years in such prestigious publications as the British journal *The Lancet* and *The New England Journal of Medicine* have shown that, in the absence of specific indications for its use, EFM not only has no demonstrated benefit in reducing childhood disabilities but may even be dangerous.

EFM plays a major role in the futile cycle of defensive obstetrics brought on by malpractice hysteria. For legal protection the physician uses the monitor so he can show, if anything goes wrong, that he "did all he could." But with the monitor readings a matter of record, his actions will be further scrutinized to see if he once again "did all he could" in response to an abnormal reading.

Alarmist reactions to insignificant variations in monitor readings contribute to the current 24-percent cesarean-section rate in the United

BY CONFINING MIDWIVES TO THE ROLE OF OBSTETRICAL HANDMAIDENS, THE LAW PREVENTS THEM FROM MAKING THEIR FULL CONTRIBUTION TO THOSE WHO WANT IT.



States (a rate twice as high as the World Health Organization recommends). Indeed, any medical intervention in childbirth tends to necessitate further intervention by disrupting the normal physiology of labor and by immobilizing, enervating, disabling, and dispiriting the mother.

A midwife strives to avoid such intervention. Rather than "deliver" the baby, she brings out the birthing woman's own physical and emotional strength—resources left untapped or suppressed by standard obstetrical practices. This is more than touchy-feely rhetoric. It translates into concrete clinical expertise: an appreciation of the variations of normal labor, of the way some problems can correct themselves with time, of the influence of emotional support and a sense of well-being during labor, and of many nonchemical, noninvasive means of encouraging progress.

An obstetrician's highly specialized knowledge represents only a narrow segment of the whole range of knowledge relevant to childbirth. A midwife draws upon a traditional body of knowledge that guides her both in forming a supportive bond with a pregnant woman and in shaping a positive experience of—and attitude toward—birth. In addition to emphasizing prenatal education and preparation, she comes to know the woman, her environment, and the way she lives, and thus can better understand her reactions and assist her during labor.

Podell writes: "The midwives gave me all the room I needed, but they were never distant; they were always right there, offering energy, a sip of juice, a word of encouragement. Their presence comforted me and gave me confidence. One thing I didn't understand....Without internal exams, how could they tell how the labor was progressing?...They said my body would know what to do and when. And to my very great surprise, they were right."

Instead of pain medication, midwives use noninvasive methods, physical as well as psychological, to help women cope with pain. The midwifery model in its pure form does not allow the use of anesthetic or analgesic drugs in normal births, since these medications interfere with the natural process of labor. Home-birth attendants avoid the use of such drugs entirely, since the safety of a home birth depends on supporting the natural process and not creating added risks. In hospitals, on the other hand, nurse-midwives sometimes make pragmatic compromises, giving pain medication to women who want it in order to make other benefits of midwifery available to them.

It should always be a woman's right to choose between midwifery and obstetrics for whatever reasons matter to her, including her preferences regarding pain medication. At the same time, as the midwifery model comes to be more widely known and better understood, more women may approach the pain of childbearing in a positive way, as Podell did: "The labor was short, intense, and sweet. It wasn't any less painful than the others, but I tried to put all my concentration on welcoming the pain, on assenting to open up. Away from the interference of the hospital, comfortable in my own familiar house, I felt a lovely sense of freedom. I wasn't anybody's patient. I was myself, doing a task I had really been preparing for since childhood."

The beneficial effects of the laboring woman's sense of well-being, comfort, and control are enhanced in the home or (to a lesser degree) in the home-like setting of a midwife-run birth center. In the words of the prominent Dutch obstetrician G.J. Kloosterman: "The advantages of home confinements are that in her own home the expectant mother is not considered a patient, but a woman, fulfilling a natural and highly personal task. She is the real center around which everything (and everybody) revolves. The midwife or doctor and the maternity aide nurse are all her guests, there to assist her. This setting reinforces her self-respect and self-confidence."

This endorsement of home birth runs counter to the prejudices of most Americans, who have been led to believe that the

ANY MEDICAL INTERVENTION IN CHILDBIRTH TENDS TO NECESSITATE FURTHER INTERVENTION BY DISRUPTING THE NORMAL PHYSIOLOGY OF LABOR.

best outcomes occur when childbirth is managed by obstetricians in hospitals where medical technology is readily available and where there is little hesitation about using it. This view equates safety with active technological intervention carried out by highly specialized personnel in an institutional setting.

Proponents of this position offer three main arguments. First, they cite the decline in maternal and infant mortality that coincided with the shift to medicalized, institutionalized childbirth in this century. But such a sweeping historical comparison is meaningless because it disregards many other changes that occurred at the same time: better nutrition, sanitation, and personal hygiene; fewer large families and closely spaced children; the development of antibiotics; and improvements in diagnosis, risk assessment, and instrumentation. Contemporaneous comparisons, such as one conducted by the New York Academy of Medicine from 1930 to 1932, have almost invariably shown that midwife-attended or home births have outcomes as good as or better than physician-attended or hospital births.

British statistician Marjorie Tew, in her 1990 book *Safer Childbirth? A Critical History of Maternity Care*, uses data from the special British birth surveys of 1958 and 1970 to make detailed comparisons—regional, historical, and individual—of the outcomes of home vs. hospital birth and of high-intervention vs. low-intervention birth in populations closely matched for risk factors. Tew concludes that increased hospitalization and obstetrical intervention cannot be credited with improving the safety of childbirth. To her, in fact, the weight of the evidence suggests that these changes have done more harm than good.

Second, opponents of midwifery argue that mortality statistics show babies are at greater risk if they are born outside a hospital. This fallacious comparison, first made in a 1978 press release by the American College of Obstetricians and Gynecologists, rests on raw statewide figures showing that the risk to a baby's life was two to five times greater in an out-of-hospital birth. But the "out-of-hospital" category included not only intentional home births, but also late miscarriages, premature and precipitous births, and unplanned home births. Such undifferentiated data say nothing about the safety of planned, properly attended home births.

Finally, when forced to confront the lack of statistical evidence in their favor, proponents of orthodox obstetrics say, "OK, so the differences in safety are too small to show up in the data. But even one unnecessary infant death is too many—especially if it's yours." This argument, while highly effective in inducing fear and guilt in parents, fails to take into account the countervailing risks of medicalized birth, such as infections resulting from hospital sepsis or from unnecessary surgical procedures and the many complications that can result from interfering with the progress of labor.

Opponents of midwifery also ignore a large body of evidence that low-intervention maternity care by midwives results in outcomes as good as or better than those of hospital births. Since 1925, for example, the Frontier Nursing Service in Kentucky has provided outstanding maternity care to a poor, geographically remote population. The service, whose midwives attended nearly all births at home (sometimes on horseback) until the late 1960s, has compiled an outcome record that compares favorably with that of mainstream America.

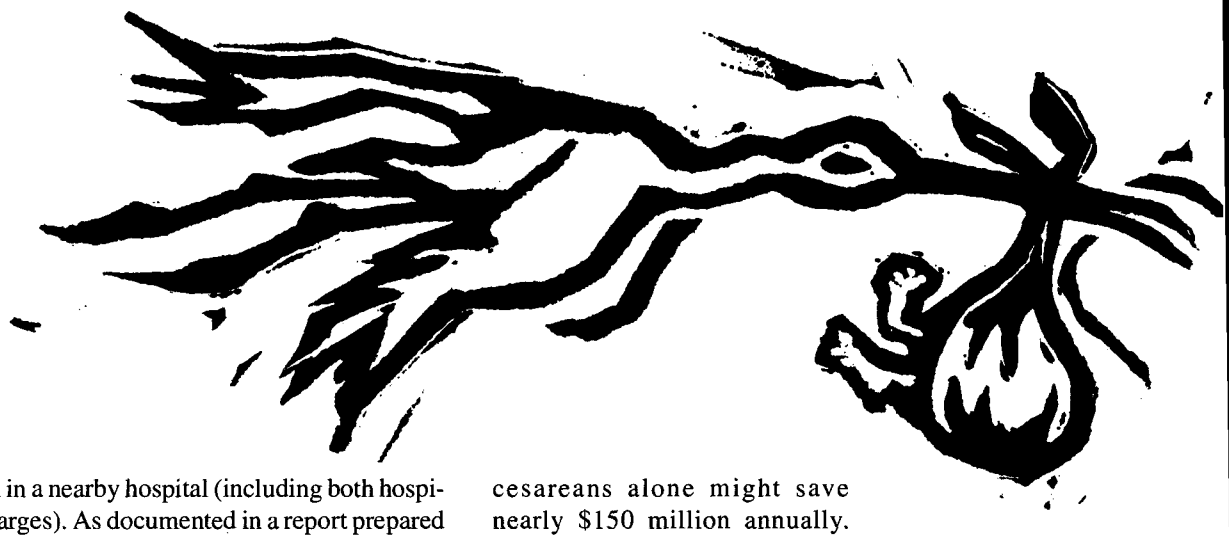
In a remarkable real-life experiment in Madera County, California, neonatal mortality dropped from 24 to 10 per 1,000 when nurse-midwives were introduced into a poor agricultural area in 1960. Pressure from the state medical association ended the program in 1963. Midwives were replaced by obstetricians, whereupon neonatal mortality rose to 32 per 1,000. The number of women receiving no prenatal care doubled.

Midwifery programs are having an important impact among the urban poor as well. With one-third of its largely black and Hispanic clients classified as high-risk, the North Central Bronx Hospital midwifery service has the lowest cesarean-section rate in New York City and lower-than-average rates of low birth weight and perinatal and neonatal mortality. In a well-controlled study involving low-income women in a Houston hospital, published in 1991 in *The Journal of the American Medical Association*, the continuous companionship of a *doula*—a woman trained to provide labor support—shortened the duration of labor, cut the cesarean-section rate in half, and reduced the need for other interventions along with the incidence of maternal fever and prolonged infant hospitalization. And the *doula* provides only part of a midwife's comprehensive skills and services.

Two years ago the National Birth Center Study reported on birth outcomes for nearly 12,000 women admitted to freestanding birth centers in the United States, three-fourths of them operated by midwives. In this largely low-risk population, the low overall perinatal-neonatal mortality rate of 1.3 per 1,000 was comparable to that of low-risk hospital births. Moreover, it was achieved with minimal intervention (most notably, a 4.4-percent cesarean-section rate), low morbidity, and high levels of satisfaction. Similar findings were obtained in a review of more than 3,000 out-of-hospital (mainly home) births attended by licensed direct-entry midwives in Arizona between 1978 and 1985.

Further evidence comes from Holland, where the national health-care system deliberately reversed a trend toward American-style hospital births a decade ago. In a study published recently in the British journal *Midwifery*, researchers who analyzed all Dutch births in 1986 found that, at all risk levels after 32 weeks' gestation, perinatal mortality was "much lower under the noninterventionist care of midwives than under the interventionist management of obstetricians." And this is in a country with an ethnically diverse population (including guest workers).

Studies also find that midwifery is much less expensive than conventional obstetrics. The cost-effectiveness of the midwifery model follows from its reliance on natural processes and settings rather than on expensive technology. In one of the first demonstrations of the cost-saving potential of midwifery, Blue Cross/Blue Shield estimated that its costs for a birth in the Maternity Center Association's Childbearing Center in Manhattan in 1976-77 averaged only 37.6 percent of the cost of an



uncomplicated birth in a nearby hospital (including both hospital and physician charges). As documented in a report prepared for the Federal Trade Commission, Blue Cross/Blue Shield's decision (against formidable opposition) to authorize reimbursement for the center was a major breakthrough in making the freestanding birth center a viable concept in the United States.

Since then, this initial indication of the savings to be achieved through broader application of the midwifery model has been borne out by other research, most notably a Health Insurance Association of America (HIAA) study published in 1989. These savings can be realized in a number of ways:

Lower fees. According to the HIAA study, the average physician's fee for a normal pregnancy and birth is $1,492, while a midwife's fee averages $994. A midwife's fee typically covers more time spent before, during, and after the birth and includes comprehensive services that otherwise would require a team of providers.

Lower site-related costs. According to the HIAA study, a normal birth involving a one-day stay in a birth center costs $2,111, compared with $3,233 for a one-day hospital stay. (These figures include practitioners' fees.) Since the average length of stay in a hospital is longer than in a birth center, the difference in practice is even greater. Thus, the average hospital cost for a normal vaginal delivery is $2,842 in addition to the physician's fee of $1,492, for a total of $4,334.

In a home birth there are no site-related expenses. In Australia, for example, an estimate published in the journal *Family Physician* indicated that insurers and families might save A$83 million a year if 30 percent of births took place at home. Of course, the cost of maintaining hospital backup for cases requiring transfer must be factored into the overall costs of out-of-hospital birth services. But such on-call auxiliary services require only a fraction of the institutional resources routinely used and paid for under the present system.

Reduced use of technology. Midwives rely much less on technical procedures that entail material costs, increased practitioners' fees, and (often) longer hospital stays. A birth by cesarean section costs an average of $7,186, compared to $4,334 for a vaginal birth in a hospital. Since midwife-attended births have a cesarean-section rate 50 percent to 70 percent lower than physician-attended births in comparable populations with equivalent outcomes, the savings to be realized from this aspect of the midwifery model are enormous. If all of New York state's hospitals operated in the manner of the North Central Bronx midwifery service, the reduction in cesareans alone might save nearly $150 million annually. Ending the indiscriminate use of other specialized procedures, such as electronic fetal monitoring, ultrasound, IVs, and episiotomy, would also save money.

Lower training costs. The Congressional Office of Technology Assessment calculated that the cost of training a certified nurse-midwife in 1985 averaged $16,800, compared with $86,100 to train a general physician, let alone an obstetrician. Since midwifery training is more appropriate for a large majority of births, there is great potential for savings here.

Lower liability costs. As of 1987, 71 percent of obstetrician-gynecologists had been named in one or more liability claims, compared with 10 percent of nurse-midwives. Direct-entry midwives (those not trained and regulated by the nursing profession) are even more rarely sued. Why these disparities? First, obstetricians deal with more complicated cases with a greater likelihood of a tragic outcome. Second, obstetricians have deeper pockets. (Like physicians, certified nurse-midwives—registered nurses with additional training in midwifery—have malpractice insurance; direct-entry midwives generally do not, except in states where they are licensed.)

Third, and perhaps most important, people who choose a midwife (especially a direct-entry midwife) commit themselves to sharing the risks and responsibili-

AS OF 1987, 71 PERCENT OF OBSTETRICIAN-GYNECOLOGISTS HAD BEEN NAMED IN ONE OR MORE LIABILITY CLAIMS, COMPARED WITH 10 PERCENT OF NURSE-MIDWIVES.

ties of birth. Rather than expect a guaranteed perfect outcome, they participate with an understanding of nature's uncertainties. The midwife actively encourages this informed participation. And because she establishes a relationship of trust, full and open communication, and emotional support, the midwife does not leave her clients feeling abandoned and resentful in the event of a tragic outcome.

Lower health-care costs after birth. The costs of childbirth pale beside those of taking care of premature and sick infants and children. According to the HIAA survey, it costs nearly $1,000 a day to keep a baby in a neonatal intensive care unit; a 30-day stay can cost $30,000. Hospitals that bear these often uncompensated costs should heed the documented success of midwifery programs, over a range of settings and income levels, in reducing the incidence of low birth weight, which is directly associated with prematurity. To the extent that midwives' emphasis on a healthy environment during pregnancy can reduce the short- and long-term effects of malnutrition, smoking, heavy drinking, and drug use on maternal and child health—in some cases preventing lifelong disability—the contribution of midwives to reducing health-care costs may be incalculable.

In the case of midwifery, the evidence is overwhelming that better care can cost less. Indeed, the American system of obstetrics is so inappropriate and inefficient that only as a protected monopoly could it have gained and held its dominant position. It could not have survived, and cannot now survive, in a free market. But the monopoly is well entrenched by law.

Direct-entry midwives are legal in some states, illegal in others. In a plurality of states their legal status is uncertain. But if a state's medical-practice act includes childbirth among the conditions exclusively reserved for medicine, then direct-entry midwifery is presumed to be illegal. And in the Catch-22 of midwifery regulation, some states (such as Rhode Island) won't let midwives practice without a license but won't license them either.

This patchwork of laws resulted in part from deliberate efforts by organized medicine to create a protected monopoly and in part from an unconscious societal assumption that midwifery had disappeared. During the past few decades, midwifery has been allowed back in a limited role in the form of certified nurse-midwives. CNMs practice legally in every state, but their scope of practice—indeed, their ability to practice at all—is often severely restricted when physicians withhold the requisite institutional or logistical support.

Direct-entry midwives are often prosecuted for practicing either medicine or midwifery without a license. Sometimes these prosecutions help clarify the legal status of midwives. In 1990, after charges were brought against a Pennsylvania midwife who attended Amish clients, a judge ruled that state law did not prohibit the unlicensed practice of "lay" midwifery. But in Illinois in 1991 a court decision calling for clarification of the state's medical-practice act led to legislation that included childbirth within the scope of the act. Midwives have also suffered setbacks in Southern states such as Alabama, where public-health departments have forcibly retired the experienced "granny" midwives who often were the only providers of maternity care for the rural or urban poor. In Arkansas, public outcry over such action persuaded the legislature to legalize direct-entry midwifery. In Georgia, however, recently issued regulations have made the practice of direct-entry midwifery a felony.

A decade ago in REASON, Sarah Foster documented the various tactics that the medical establishment uses to intimidate and exclude midwives ("Up Against the Birth Monopoly," September 1982). In one of the more prominent cases to have occurred since then, a local obstetrician pilloried nurse-midwife Debby Sweeney in front of her students at the Medical College of Georgia School of Nursing in 1986, falsely charging that she was practicing medicine illegally and endangering her patients. The obstetrician's group practice prevented Sweeney from continuing to teach in one of the hospitals affiliated with the college, complaining that they "could not allow their patients to be exposed to students who are being instructed by one who advocates the home delivery concept." Sweeney had run afoul of the medical establishment by advertising her home-birth practice.

Such anticompetitive tactics thus far have limited the availability of qualified attendants for out-of-hospital births and deprived women and families of information about birth options. Unless a woman happens to know someone who knows the local midwife, she may see and hear only horror stories about home birth.

Reform is coming, however. Many prestigious institutions are calling for more widespread adoption of midwifery or a low-intervention approach to childbirth. These include the World Health Organization, the European Economic Community, the Institute of Medicine, the Office of Technology Assessment, the General Accounting Office, the American Public Health Association, and the National Commission to Prevent Infant Mortality. The strongest advocacy has come from the women's health movement. A detailed position paper issued jointly in 1990 by the Women's Institute for Childbearing Policy, the National Women's Health Network, the National Black Women's Health Project, and the Boston Women's Health Book Collective argues for a midwifery-based maternity care system that favors out-of-hospital birth settings.

The great stone face of the birth monopoly is visibly cracking. Hospitals hit hard by the loss of obstetricians are advertising for midwives. HMOs, after considerable resistance, are incorporating midwifery services. Boston will be joining New York, San Diego, and other localities in setting up a public out-of-hospital birth center for low-income women. At the federal level, direct reimbursement for midwives has been mandated for the armed services, Civilian Health and Medical Programs of Uniformed Services (CHAMPUS), and Medicaid. One by one, state governments are authorizing limited prescrip-

depends primarily on private supply.

I had long been a fastidious reader of the studies produced by the Reason Foundation and our own economists to the effect that private suppliers of services ranging from garbage collection to river dredging operate more efficiently than their public-sector counterparts. Yet here was evidence that in one of the most complex and expensive aspects of modern life, public service meant efficient service.

And the evidence, in the form of the historic trends in health-care costs as a fraction of the total national income, was quite compelling. Whereas health-care costs had absorbed a greater fraction of the Canadian GDP in the years before full-fledged Medicare emerged in 1971, ever since health care has absorbed a greater fraction of U.S. GDP—currently 12 cents of every dollar compared to just less than 9 cents in Canada.

The question is, How does Canada do it? How do we produce the same health-care product for only 9 cents of every dollar of GDP?

CANADA DOESN'T CONTROL THE COST OF INDIVIDUAL MEDICAL PROCEDURES. INSTEAD, IT LIMITS THE TOTAL AMOUNT SPENT ON HEALTH CARE.

To understand the question, one must first understand the system. It is not entirely correct to refer to "the Canadian health-care system," for it actually includes 11 separate provincial and federal health-care programs operating under the umbrella of the National Health Act. The federal government provides a significant but declining fraction of health-care funding. It also tries to ensure national standards, portability of coverage, and elimination of co-insurance payments or user fees by penalizing provincial governments that break the rules.

Patients may pay extra for semi-private and private hospital rooms since the basic service covers only ward accommodation. Patients may also pay for services that aren't covered by the hospital plan, including elective plastic surgery or outpatient physical therapy. They may not, however, pay a doctor anything more than the government's fee for covered services, and the doctor may not accept any extra payment.

(This prohibition extends to hospital services or surgical procedures. Canadian patients may not "jump the queue" by paying directly for procedures in short supply. Patients of other nationalities may, however, get access to Canadian health care faster than Canadians by paying the full cost themselves. The argument used to justify this practice is that letting foreigners pay cash generates more money for the health-care system and hence enables more Canadians to be treated.)

So why does Canada do things so much more cheaply than the United States? The most significant fraction of the difference, according to the *New England Journal,* is in the costs of administering the two systems. To administer the U.S. system takes 1.23 percent of GDP, compared to a mere 0.1 percent for the Canadian system.

Add to that the fact that Canadian physicians are protected from unlimited liability by a Supreme Court–imposed ceiling on pain-and-suffering damages and the further fact that we have a younger population, and considerably more than half of the difference is accounted for. What's more, notes Victor Fuchs, a Stanford University researcher and noted health-care authority, Canadian doctors charge smaller fees. Casual observation of the salaries offered by American recruiters at nursing job fairs in Canada indicates that other health-care personnel also earn more in the United States.

But even all these factors do not entirely account for the difference. There is, after all, the pesky matter of the demand for health care. Since 1971, Canadians have had universal access to the medical system—with fees of any kind forbidden by law. Health care is, in other words, a free good. And, as a Royal Commission of Enquiry determined in 1976, "the demand for health care appears to be unlimited." In such a system, we would expect demand for care to skyrocket, taking costs along with it.

Oddly enough, this hasn't happened. The reason is simple, though not obvious: Canada doesn't control the unit cost of health care—the cost, for instance, of an appendectomy—but the total cost. Each provincial govern-

KERI ROSEBRAUGH

THE FRASER INSTITUTE SURVEY OF PHYSICIANS 1991

AVERAGE WEEKS WAITED BY SPECIALTY

	B.C.	N.B.	Nfl.	Man.	N.S.
Plastic	13.2	36.2	37.0	11.0	26.3
Gynecology	8.4	10.9	5.3	9.0	9.6
Ophthalmology	11.6	5.2	2.9	12.8	10.7
Otolaryngology	12.2	7.2	N/A	7.0	14.7
General Surgery	4.0	2.5	8.0	8.2	4.0
Neurosurgery	4.2	8.3	9.0	10.5	5.8
Orthopedic	15.8	14.6	18.5	20.6	19.7
Cardiology	14.0	10.0	42.6	14.7	26.0
Urology	8.3	13.2	5.0	6.7	7.1
Internal Medicine	5.5	4.5	2.2	3.3	2.0

ESTIMATED PATIENTS WAITING BY SPECIALTY

	B.C.	N.B.	Nfl.	Man.	N.S.
Plastic	1,214	428	1,028	263	660
Gynecology	2,179	921	525	1,255	366
Ophthalmology	1,623	289	70	710	662
Otolaryngology	2,177	363	N/A	651	585
General Sur.	1,693	300	383	1,519	676
Neurosurgery	608	64	60	319	238
Orthopedic	3,432	543	391	1,260	828
Cardiology	878	63	90	320	300
Urology	2,319	1,074	199	402	916
Internal Med.	1,081	129	89	156	217
Residual*	23,201	725	1,913	4,351	5,223
Total	**40,405**	**4,899**	**4,748**	**11,206**	**10,671**
	260,721**				

* Residual waiting: Estimated number of people waiting for operations not covered by survey.
** Estimated total for Canada.

ment sets a health-care budget for the year and pays each hospital accordingly. Although nominally independent, hospitals depend entirely on these politically determined budgets for their revenue.

No matter how much demand there may be, the hospitals usually do not receive any additional payment. Any operating deficit must be made up in the next fiscal year. To meet these restraints, hospitals limit the total number of complicated surgeries—cardiac bypasses, hip replacements—they can do in a particular budgetary period. They also reduce the number of available beds to bring their total operating expenses down to the budgeted figure. This practice, on a system-wide basis, amounts to rationing.

The provincial governments also control hospitals' capital budgets—thereby limiting the acquisition of such new technologies as CAT scanners, MRI scanners, and lithotripters. And the governments allocate money separately for such special procedures as cardiac bypass surgery, rationing them as well. As a result, there are many fewer angioplasty sites, open-heart surgery sites, and organ transplant facilities per capita in Canada than in the United States.

Although physicians are paid on a fee-for-service basis, with fees negotiated collectively, they, too, are limited to a fixed amount of total billing. If total billings exceed the budget for a certain period, each physician's payments in the next period are reduced to make up the difference.

So the answer to the question, How do they do it in Canada?, is that they do not do it. The total cost of health care is controlled by arbitrarily limiting the number of procedures of certain types, by limiting access to technology and diagnostic machinery, and by compensating physicians so that they are discouraged from responding to the demands of their patients. There are measurable consequences of this supply limitation in the form of queues or waiting lists for surgery.

ARTHUR MATSON

As the celebrated case of Stanley Roberts, former president of the Canadian Chamber of Commerce, makes clear, being insured in Canada is no guarantee that you will receive medical care when you need it—even if the required treatment is a fairly standard procedure. Roberts was admitted to Burnaby General Hospital near Vancouver with neurological symptoms—memory loss, speech impediment, headache. The cause, it was determined, was either a tumor or an abscess.

If an abscess, it needed immediate treatment, since these can fulminate and kill the patient relatively quickly. If a tumor, while potentially just as deadly if malignant, there would be more time to treat it. Roberts was placed on the waiting list for neurosurgery to have a biopsy or other definitive test of his malady. It turned out to be an abscess—a fact determined by an autopsy after Roberts had died. For Stan Roberts, a personal friend and a man who had done much for Canada in many capacities during his life, the waiting list for diagnostic surgery proved to be too long.

BEING INSURED IN CANADA IS NO GUARANTEE THAT YOU WILL RECEIVE MEDICAL CARE WHEN YOU NEED IT—AND WAITING SOMETIMES MEANS DEATH.

Until recently, such tragic anecdotes accounted for most of our knowledge of Canadian waiting lists; there was little hard information available. But the Fraser Institute has just completed a five-province study of patient waiting. Surveys of specialists were conducted in the Pacific coastal province British Columbia; in Manitoba, a centrally located province; and in three Atlantic provinces, Newfoundland, Nova Scotia, and New Brunswick. The results of these surveys are reported in Tables 1 and 2.

In all, 333 physicians representing 10 different specialties were surveyed—20 percent of the total number of practitioners in each of the fields of specialization. Physicians were asked to indicate how many patients they had waiting for procedures of different kinds and how long people were waiting before they got the service they needed.

These survey responses constitute a unique source of information, because comprehensive surveys of this kind have not been conducted by others and, in particular, no waiting list measurements are published by governments. Table 1 shows the number of weeks patients are waiting for a variety of types of surgery. Table 2 provides the estimates of the total number of people waiting for surgery. Table 2 provides, in addition, an estimate of what these figures imply about the total number of people waiting in the country as a whole.

The waiting lists reveal quite a bit about how the Canadian system has adapted to the unlimited demand for health care. Generally, waiting was longest in cardiology, orthopedics, and plastic surgery. Patients in Newfoundland needing cardiac surgery wait an average of 42.6 weeks, an experience matched only by the 37-week average wait for plastic (restorative) surgery in Newfoundland. Waiting lists were, on average, shortest for internal medicine, where the longest wait, in British Columbia, was just over a month. In general, the waiting times for gynecology, urology, and general surgery were short—ranging from 0.9 week to 13.2 weeks.

It would be helpful to know whether Canadian waiting lists are getting longer or shorter over time. Although there are no comprehensive waiting-list data, we can compare a 1990 measurement for British Columbia to the 1991 estimates for that province. And the result is striking: There has been a significant decline in waiting times and, in some categories, a dramatic decline. In the case of general surgery, for example, the waiting time dropped from 23.9 weeks to 4 weeks. In the case of urology, from 25.6 weeks to 8.3 weeks.

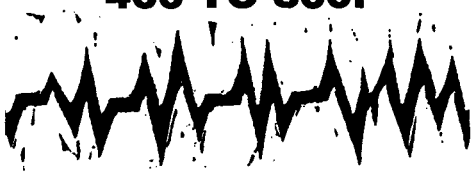
The explanation for this apparently good news is not, however, all that encouraging. In 1989, there was a general strike by the nurses in British Columbia, boosting the length of waiting lists dramatically. When the strike was over, waiting lists shrank.

But they didn't necessarily return to normal. Consider the effects on cardiac-surgery waiting lists, as examined in an

August 1991 *Journal of the American Medical Association* article by Steven J. Katz and his colleagues. In the first quarter of 1989, 400 people were waiting for bypass surgery. The province's nurses then began a work-to-rule campaign, followed by a 17-day strike. During the strike, no bypass surgeries were performed. And even after the strike there was a shortage of critical-care nurses. The result: nine months of less-than-capacity operating levels and a drop in the average number of procedures per quarter, from 600 to 400. By late 1990, when the number of operations finally returned to normal, some 800 people were waiting—twice the number before the strike.

The waiting list still hasn't returned to its previous level. Our measurements show 669 people waiting in 1991, a 67-percent increase from before the strike. Because there is no unused capacity to do cardiac surgery under ordinary circumstances, the strike permanently lengthened the waiting list. (Fortunately, this problem hasn't emerged for other surgeries, except orthopedic, suggesting that those surgeries are not as dependent on specialized nurses or equipment.)

A 1989 NURSES' STRIKE IN BRITISH COLUMBIA DOUBLED THE NUMBER OF PATIENTS WAITING FOR CARDIAC BYPASS OPERATIONS, FROM 400 TO 800.



We have one other clue to the status of waiting lists over time. We have recently discovered a 1967 government report compiling waiting lists for a number of the larger hospitals in British Columbia and projecting these waiting lists for the province as a whole. From these projections we can calculate that 0.6 percent of the population of British Columbia was waiting for surgery in 1967. (At that time, a comprehensive system of hospital insurance had been in place for 10 years. Comprehensive public insurance of physician costs did not arrive until the following year.) The total number estimated in our new survey amounts to about 1.24 percent of the population for 1991—double the earlier figure. This suggests that the waiting-list problem may be getting worse.

Moreover, contrary to U.S. advocates of a Canadian-style system, national health insurance doesn't mean equal access to health care—or equal health. One striking difference is from province to province. A woman in Newfoundland might wait 36.2 weeks for restorative surgery after a radical mastectomy, while she would wait only 13.2 weeks in the more-affluent province of British Columbia. For potentially life-preserving cardiac surgeries, the difference is even larger—a disparity of 32 weeks between the longest and shortest wait. And even that disparity is misleading: New Brunswick has a short waiting list because that province only recently began to offer cardiac bypass surgery at all.

So, what can we conclude from all of this measurement of health-care supply and demand in Canada? The most obvious inference is that while it is true that Canada has a good health-care system, that system does not contradict the general rule that governmental production of services is expensive. Canada spends less of its GDP on health care not because we have found a way to produce health care at lower unit costs but because we have found a way to limit the total supply of services made available. We do not permit prices to play a role in allocating health-care resources in Canada. Instead, we ration the supply, denying treatment to some and making others wait.

A second inference from the data is that in Canada neither access to health care nor medical outcomes are equal. People wait longer in some provinces than in others, and some medical technology is available in some provinces but not others. Waiting, which is the only alternative for low-income Canadians, encourages high-income Canadians to go to the United States for treatment. The clear indication is that Americans should not adopt the Canadian health-care system in the mistaken belief that it will solve the problems of access and high cost.

Michael Walker is executive director of the Fraser Institute in Vancouver.

DOCTORS WITHOUT BILLS

SAVING THE WORLD A PATIENT AT A TIME

The city of Roanoke, near the base of Virginia's Blue Ridge Mountains, is a place much like any other medium-sized American town. It has an older, sleepy downtown and bustling suburbs. It has a rich section and a poor section, crime that is troubling but not overwhelming, schools that are good but could be better.

But on a tree-lined side street, not far from the city center, stands a sprawling one-story building that has made Roanoke something of an example for the rest of the country. It is the Bradley Clinic, a free clinic where all the doctors and nurses are volunteers, and where none of the thousands of area residents served every year are charged a penny for the care they

BY MALCOLM GLADWELL

receive or the drugs they are prescribed.

There are hundreds of free clinics like this in cities around the United States, privately run volunteer groups providing free health care to some of the 31 million Americans without insurance. Few, however, have been as successful as Bradley in attracting community support and providing quality care. While other charity groups rely heavily on lay help and have difficulty attracting medical professionals, the Bradley leadership has convinced 120 of the city's 411 physicians to donate their time. Dozens of the city's most prominent businesses supported the clinic's recent fund-raising drive, and the clinic's board of directors reads like a local Who's Who.

And while many free clinics are run on a shoestring, often out of the backs of churches, Bradley has a 1-year-old facility indistinguishable from a paying clinic. Equipment is state of the art. The grounds are immaculately landscaped. There is a full-service pharmacy.

The success of the Roanoke clinic has inspired the creation of at least eight other clinics around the country and led the White House to name the organization one of the nation's "thousand points of light." It has also thrown a hitherto ignored question into the ongoing national debate over how best to solve the nation's health-care ills: To what extent can volunteerism and old-fashioned charity answer the needs of the country's uninsured?

The conventional wisdom says they can't. The idea of charity cannot be found in the current debate in Washington over health-care reform. Even other free-clinic operators, who have had little of the success of the Roanoke group, consider their efforts only a stopgap measure before Congress enacts a more comprehensive solution.

But the physicians and volunteers at the Bradley Free Clinic have become crusaders for charity care. They are planning a national foundation to encourage and assist in the establishment of free clinics all over the country.

"We've got institutionalized thinking in this country," says John Rocovich, a Roanoke tax attorney who serves on the Bradley board. "Everyone is in institutionalized government, institutionalized medicine, institutionalized health insurance. What we have here is a simple, straightforward idea. In America we have a level of volunteerism you just don't see elsewhere. With volunteerism we can take care of those people who slip through the cracks so much more cheaply than the government that it makes sense."

"People in this country have a sense that local solutions, not sweeping solutions, can't accomplish anything," says Kevin Kelleher, a volunteer physician at the Bradley clinic. "They are wrong."

Free health care for the poor is a concept as old as American medicine itself. In the 19th century, many hospitals were set up by churches or nonprofit groups explicitly to provide services free of charge. Even as late as the early 1970s, many American hospitals had rules requiring that physicians provide a certain number of hours of free care every week in exchange for hospital privileges.

With the introduction of Medicaid and Medicare in 1965, the need for organized charity greatly diminished. At the same time, formal programs to encourage charity care also disappeared.

But there are still an estimated 31 million Americans who do not have health insurance, either because they are ineligible for it because of serious health conditions, because their jobs do not offer it, or because they cannot afford it. These people are too young for Medicare and too well paid for Medicaid.

Without medical coverage, the uninsured pay directly for about half of the care they receive. For the rest, they depend on the kindness of others. Hospitals, for example, spend about $10 billion a year providing free care and forgiving patients' debts. Private philanthropy pays for $2.7 billion in hospital care, while federal, state, and local government sources kick in another $45 billion for public clinics and other services outside of the mainstream of Medicaid and Medicare programs. In addition, individual physicians make countless decisions to reduce or waive the cost of their services for those without insurance.

The patchwork of services gives the uninsured far less care than

KERI ROSEBRAUGH

FREE CLINICS ARE LOCATED IN POOR NEIGHBORHOODS AND HAVE HOURS THAT ACCOMMODATE WORKING PEOPLE.

FREE CLINICS CAN DELIVER BETWEEN $5.00 AND $6.00 OF MEDICAL CARE FOR EVERY $1.00 IN REVENUE.

they would receive were they fully covered. Overall, annual per capita health-care spending for the uninsured, for example, is $866, compared with $1,437 for the insured population.

This doesn't mean that the uninsured don't get life-saving operations when they need them. No hospital turns away a patient with a burst appendix. Rather, the uninsured get less primary and preventative care than the insured. Because of Medicare, the uninsured are younger than the insured, but they appear to be in poorer health than insured people of the same age.

The uninsured see a doctor only two-thirds as often and are three times more likely to be hospitalized for a preventable condition or disease, according to a 1990 study for the Health Care Financing Administration. Markedly fewer uninsured than insured women have their blood pressure checked or a Pap smear or breast exam done. Pregnant uninsured woman are far more likely to have little or no prenatal care and to have low-birth-weight babies than the insured.

The uninsured also receive much less elective surgery than the insured do. According to a Georgetown University study reported in the January 16, 1991, issue of *The Journal of the American Medical Association*, they are 75 percent less likely to receive a knee replacement, 45 percent less likely to receive a hip replacement, and 29 percent less likely to receive a coronary bypass.

It was to meet this need that free clinics began to spring up in the late 1960s and '70s. Today, there are about 200 of them nationwide—chiefly small, shoestring operations serving inner-city areas and surviving largely on a combination of volunteers, individual donations, United Way money, and some tax dollars.

The free-clinic model has clear advantages. By using volunteers and donated drugs and equipment, clinics provide highly cost-effective care. Studies have shown that free clinics can deliver between $5.00 and $6.00 of medical care for every $1.00 in revenue. The Bradley Clinic provided just under 7,000 physician visits in 1990 and filled more than 10,000 free prescriptions on an operating budget of just over a quarter of a million dollars.

Clinics are found in poor neighborhoods, where the need for medical service is greatest. This solves transportation problems that can inhibit the use of hospitals and other medical services by the uninsured. And clinics remain open after working hours to accommodate their volunteer staffs and their patients.

"Access and transportation are big problems for the uninsured, and accessibility is limited by any other solution," the Bradley Clinic's Kelleher wrote in a recent *JAMA* article on the free-clinic phenomenon. "Familiarity also encourages use....A strong identification occurs with a neighborhood clinic that encourages responsibility, pride and additional volunteerism."

As loosely structured local groups, free clinics also have the virtue of flexibility. At the Washington Free Clinic in the District of Columbia, for example, where the typical medical need is obstetric and gynecological care for the local Hispanic population, the clinic tailors its services to its neighbors.

"Using lay workers we're able to take the time to really explain to each patient how their body works, what problems they are having," says clinic director John Clark. "To give an example, an adolescent coming in for her first gynecological exam here will get an hour and a half of education. In a doctor's office, she might get 15 minutes."

But few free clinic operators tend to share the optimism of the Roanoke group about their ability to meet the needs of the huge numbers of uninsured Americans. In a typical day, Clark says, the D.C. clinic probably turns away 20 to 25 people because it simply doesn't have the staff or resources to deal with them.

"I think there are 114,000 people in D.C. without health insurance," he says. "In a year we probably see 4,000 of those. We're only scraping the surface. To serve the need in this city we would have to turn into a multimillion-dollar, several facility organization."

Clark has difficulty recruiting doctors, although the Washington, D.C., area has the highest number of doctors per capita of any urban area in the country. While locating the clinic in an economically depressed area makes it most accessible to those in need, he says, it also makes it almost

impossible to convince doctors to volunteer.

"We're located in a drug area where there are lots of concerns about safety," Clark said. "Doctors get their cars broken into. The clinic is oppressively hot in the summer and freezing cold in the winter. They have to work without a lot of medical support. It's a difficult setting."

These complaints are echoed by other free-clinic operators around the country. At the Cleveland Free Clinic, one of the largest in the country, about 32 physician volunteers see about 20,000 patients a year in a city that has about 200,000 people without health insurance.

The clinic would like to have at least twice as many doctors. "There is never a night here when we don't have more people in the waiting room than we are able to see that evening," says clinic director Marty Hiller.

A veteran of the free-clinic movement, Hiller has grown skeptical of the role clinics can play in solving America's health-care problems. "We are the crisis response," he says. "We exist because there is a problem and we are able in the short run to meet the needs of some. But I don't see free clinics as necessarily being the solution. When the health-care system takes care of people without insurance, we will no longer have to be here. Our long-term goal is not to exist."

Which of these two very different pictures—the optimism of the Bradley Free Clinic or the pessimism of other free-clinic operators—represents the most realistic picture of free care is difficult to say.

Certainly, the Roanoke movement has clear advantages over its predecessors. The majority of the nation's free clinics were formed—and remain—philosophically and operationally in opposition to the local medical establishment. As part of their late-'60s counterculture heritage, many clinics remain outsiders in their communities, highly critical of the status quo.

The Bradley Clinic, by contrast, is very much a creature of the local city establishment, which has made attracting financial and volunteer support much easier. While the Washington Clinic's board of directors is chaired by a free-lance writer and peopled largely with clinic volunteers, the Bradley Clinic's board includes prominent local attorneys, businessmen, and physicians. In a recent fund-raising drive, headed by the publisher of the local paper, one wealthy Roanoke patron gave the clinic a $1-million gift.

The clinic has been so integrated into the local medical community that volunteering is almost seen as a routine extension of the obligations of the profession; more than a quarter of all local M.D.s volunteer. In all, the clinic has close to 400 volunteers, including 120 physicians, 58 nurses, 29 pharmacists, 12 laboratory technicians, 20 dentists, and 15 dental assistants. Unlike its counterparts, it has no staff shortage.

But if generating a strong community spirit is possible in Roanoke, it might not be in a larger, less close-knit community. So far clinic officials have found the biggest audience for their ideas in other medium-sized cities or large towns. Whether the medical communities of bigger cities could produce the same level of support is something that even some Roanoke volunteers doubt.

And they concede that their clinic does not entirely meet the needs of their own community. With 7,000 patients visiting a year, the organization probably serves about 16 percent of Roanoke's uninsured.

The difference, though, is that Bradley volunteers see this fact less as a reason for defeat than as an inducement to work harder. The clinic is planning additional nights of operation and setting up a cancer-screening program. A network of specialists who will accept referrals without charge has been organized.

"I don't know if a free clinic will provide all the answers, ever," says Kelleher. "But it does provide an immediate solution. It is something we can do now."

Nor does everyone think a national health-care plan would eliminate the need for free clinics. "In all the thousands of years of recorded history, we have yet to have an adequate health-care system," says John Gavin, a Roanoke emergency room physician involved with the clinic since its founding. "I don't think that in my lifetime we will see a system that will properly fill all the gaps. The gaps will change, but they will still be there.... We will always be able to make a difference."

Malcolm Gladwell is a reporter at The Washington Post.

BY USING LAY VOLUNTEERS, CLINICS CAN GIVE PATIENTS MORE ATTENTION THAN REGULAR DOCTORS WOULD.

CLEARING THE RUBLE

BY STEVE H. HANKE AND KURT SCHULER

About the only thing the Soviets ever learned to produce was the ruble. Indeed, the printing presses at the Gosbank have been working at full capacity, churning out rubles around the clock. The only thing that might jeopardize the chance to set a world record for inflation is a paper shortage.

If the Commonwealth of Independent States hopes to ever introduce markets, it must replace the ruble with a convertible, stable currency. A sound currency serves as a satisfactory store of value, medium of exchange, and unit of account. An unsound currency such as the ruble does none of these things.

An unsound currency inhibits a nation's ability to liberalize its economy. For example, inflation causes people to "save" by hoarding commodities, rather than by holding money or other financial assets. That Russian or Ukrainian farmers refuse to sell their produce for rubles should not surprise us.

The outside world will not accept inconvertible currencies as a medium of exchange. This impedes foreign investment and trade, which promote economic growth. Exports from the former USSR to the outside world are at pathetic levels, ranging from 1.2 percent of net material product in Kirghizia to 8.6 percent in Russia.

Nor is an unstable currency a good unit of account. Inflation distorts prices and makes business calculations more difficult. Hence it becomes harder to establish and enforce such essential elements of a market economy as contracts and accounts.

Unfortunately, CIS leaders believe a central bank is the way to make the ruble convertible. Guided by experts from the International Monetary Fund, World Bank, and Harvard University, they are busy learning how to run central banks. That central banking fetish could prove to be disastrous.

Central banks in developing countries have very poor records. The World Bank classifies 99 countries—mostly developing nations—as low- and middle-income, and their average annual inflation rate was 16.7 percent from 1965 to 1980 and 53.7 percent from 1980 to 1989. The political pressures for inflation are ferocious in these countries, and the central banks there lack the independence to counteract those pressures.

Even Paul Volcker, former chairman of the Federal Reserve Board, questions the value of central banks for developing nations. Addressing a group of central bankers in Jackson Hole, Wyoming, in 1990, Volcker noted that markets developed long before central banks and that the reliance on central banks in former communist nations might actually retard their transition to markets.

There is a better way: a currency board instead of a central bank. A currency board issues notes and coins convertible into a foreign reserve currency at a fixed rate on demand. As reserves, the board holds high-quality, interest-bearing securities denominated in a reserve currency. (If local officials don't want to rely on fiat currencies, the board may also denominate its reserves in gold or other commodities.) A board's reserves are equal to 100 percent of its notes and coins in circulation.

A currency board does not accept deposits, and it generates income from the difference between the interest earned on the securities it holds and the expense of circulating its notes and coins. Unlike a central bank, a currency board has no discretionary monetary policy. Instead, market forces alone determine the domestic money supply.

More than 60 countries (mainly former British colonies) have had currency boards. All successfully maintained convertibility at a fixed exchange rate. Each nation enjoyed these benefits: the same low inflation rates as the metropolitan centers (such as London) they were linked to by reserve currencies; branch banks from those metropolitan centers; access to capital at competitive rates; indigenous firms, often with corresponding arrangements in the metropolitan centers, to mediate between local savers and investors; and prices roughly in line with those in the international sphere.

When the colonies gained independence, misplaced nationalism motivated many of the newly independent countries to replace currency boards with central banks. The former colonies mistakenly thought, as the former Soviet republics now do, that the only way they could have their own currencies was to have their own central banks.

The new central banks adopted discretionary monetary policies, which caused the new currencies to deteriorate sharply,

DAVE BHANG

making most inconvertible. The central bank-issued currencies became sources of national embarrassment rather than national pride.

Currency boards still exist, however, in Hong Kong, in Brunei, and (in a modified form) in Singapore, where they continue to operate with great success. The Hong Kong currency board was established in 1935, linking the Hong Kong dollar to the pound sterling. More recently, the U.S. dollar has served as the Hong Kong dollar's reserve currency. Real per-capita income in Hong Kong has grown annually by 6.3 percent from 1965

History indicates that a currency board could give the new Commonwealth of Independent States a stable, convertible currency within weeks.

to 1989—the fourth highest growth rate among the 124 countries the World Bank tracks. And Hong Kong has attracted foreign investment, enabling it to grow despite the merchandise trade deficits it has experienced in most years since 1935.

Hong Kong actually abandoned its currency board in 1974; until 1983, the Hong Kong dollar was a floating currency. Exchange rates, the money supply, and inflation became far more volatile in that period than they had been before. In 1983, when it appeared that China might seize the colony, the value of the currency plummeted. To save the Hong Kong dollar, the currency board returned. Since then, even with uncertainty about Hong Kong's future after integration with China in 1997, the Hong Kong dollar has remained at a fixed rate of HK$7.80 per U.S. dollar.

Russia briefly had its own currency board. When troops from Britain and other Allied nations invaded northern Russia at the close of World War I, they found monetary chaos. The Russian civil

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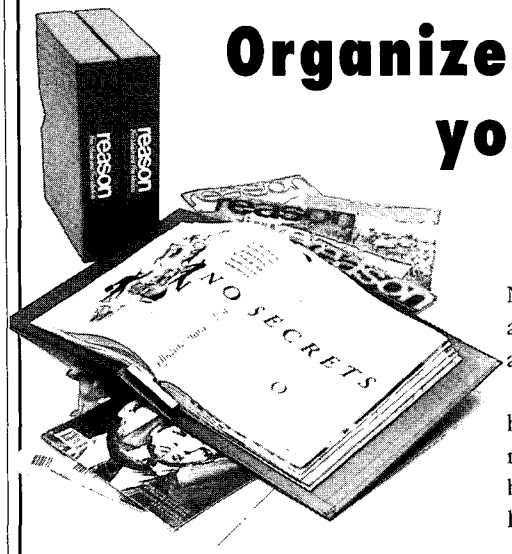

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war had begun, and every party to the conflict had issued its own near-worthless currency; there were more than 2,000 separate issuers of fiat rubles.

To facilitate trade with northern Russia, the British established a currency board there in 1918. The National Emission Caisse issued "British ruble" notes, backed by British pounds sterling and convertible into pounds at a fixed rate. British Foreign Office archives reveal that the father of the British ruble was none other than John Maynard Keynes, who was a British treasury official at the time.

Despite a raging civil war, the British ruble was a great success. The currency never deviated from its fixed exchange rate with the British pound. The British ruble was a reliable store of value, medium of exchange, and unit of account. In consequence, it drove other rubles out of circulation in northern Russia. With British rubles, the Allied army was able to buy and sell goods almost as easily as if it were home on maneuvers. Unfortunately, the British ruble didn't last long: The National Emission Caisse ceased operations in 1920, after Allied troops withdrew from Russia.

To avoid economic disaster, the CIS should borrow a page from John Maynard Keynes. Keynes's script requires the establishment of a currency board, which would issue a new local currency. The currency would be fully backed by a reserve currency and convertible into that currency at a fixed rate. That rate would be set so as to render exports competitive.

The CIS would not need huge reserves to establish a currency board because the real value of the ruble supply is only about $5 billion. To obtain reserves, the republics could liquidate the vast assets of the outlawed Communist Party and convert the proceeds into a reserve currency.

To make the currency board credible and to ensure the safety of its assets, it should incorporate and be based in a safe haven such as Switzerland. And to insulate the board from government manipulation, the majority of its directors should be foreign nationals, designated by private institutions, such as leading commercial banks, in their home countries.

A currency reform along the lines we suggest would provide a convertible currency within weeks. Following World War I, even with the delays from printing British rubles in London and shipping them to Russia, the British ruble was introduced just 11 weeks after Keynes proposed it. That's a pretty quick turnaround, even compared to the pace of change in what was, until recently, the Soviet Union.

Steve H. Hanke, professor of applied economics at the Johns Hopkins University, advises Albania, Bulgaria, and Ukraine on currency reform. Kurt Schuler is a graduate student in economics at George Mason University.

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EVERYTHING'S UP TO DATE

BY BLAKE HURST

My daughter, Annie, attends the elementary school in Westboro, Missouri. I sit on the local school board. The social event of the winter season here is the school Christmas program. But last Christmas, it was clear that all is not well with our school.

As we arrived, all of the cars followed a rather circuitous route to avoid the collapsed culvert we can't afford to fix. The music-room roof leaks. And the third floor of the 80-year-old school building has been closed because the district can no longer afford a high school. In fact, we have only four teachers for kindergarten through sixth grade.

Meanwhile, in Kansas City, the state will spend over $200,000 this year just to maintain the Olympic-sized swimming pool in one of the district's schools. And part of that money comes from Westboro and other similar school districts.

In 1984, a federal court found the Kansas City school district and the state of Missouri liable for past segregation. Although official segregation had ended in 1954, Kansas City, like many other urban school districts, had seen a continuing decline in the number of white students as white families moved to the suburbs.

When the desegregation case first went to court, the Kansas City school district claimed to have achieved "internal desegregation." After Judge Russell Clark reconstructed the case, the school district claimed it "had not eliminated all the vestiges of the prior system."

To attract white students to the Kansas City schools, Clark ordered the state and city to equip the schools with swimming pools, greenhouses, farms, and, in one school, a log cabin. That's right, a log cabin. The state must pay three-quarters of the cost of these amenities. And if the Kansas City school district can't afford to pay all of its share, the state must pick up the difference.

In other words, the Kansas City school district gets major improvements in its physical plant—a billion dollars' worth—at the expense of the state of Missouri. With that great deal at stake, we can expect the school district *never* to eliminate the last vestiges of segregation.

To attract white students, the state and city had to equip the Kansas City schools with swimming pools, greenhouses, and, in one school, a log cabin.

In Missouri, the state plugs the money it allocates for education into a formula that determines the funds each school receives. If less money is available, then each school finds its funding reduced.

In 1991 alone, the state spent more than $10,000 per student on desegregation in Kansas City. Here in Westboro, students got about $3,500 each. The state contributed a little over $1,000 per student.

Westboro has nothing to compare with Kansas City's Pitcher Classical Greek Academy, with its emphasis on athletics. Or K.C.'s Military Magnet School, with its $1.3-million field house and $150,000 weight room. Or the model United Nations, wired for language translation.

One Kansas City school spent $700 each for 30 light fixtures. If we had an extra $700, I imagine we could fix the roof. Another school was torn down after $600,000 was spent to renovate it, and its replacement will cost $32 million. The Computers Unlimited magnet school has a computer for every two students. Well, we've got computers in Westboro, too. Four. But only because a local grocery ran a promotion trading computers for sales receipts. Our principal and some of the mothers gathered more than 10,000 receipts to purchase our computers.

Our superintendent doubles as the kindergarten teacher. And the librarian. In her spare time, she teaches social studies to the fifth-graders. All for around $20,000 a year. Kansas City pays its new superintendent, Walter Marks, $300,000. Our superintendent has never been investigated by a grand jury. However, a grand jury in California concluded that Marks had mismanaged the budget of his former employer, the Richmond school district. Since Judge Clark wasn't providing funding for the district in California, it went into bankruptcy.

Clark brought our loss, and Kansas City's gain, into sharp focus this summer when he appropriated another $71 million—almost 10 percent of the total state budget for education—to cover overruns in K.C.'s construction budget. Every other school district in the state, including Westboro, had its funding cut.

When the state complained about the cost of the desegregation remedy, the plaintiffs' lawyer, Arthur A. Benson II, said, "We are fighting for scraps of food on the plate, when we should be fighting to put more food on the plate." Well, Mr. Benson, a billion dollars may be scraps in Kansas City, but it's real money in Westboro. Incidentally, the state pays the fees for Benson and his colleagues. So far, their fees alone would operate the Westboro school system for nearly 10 years.

At our next board meeting, we'll try to decide what to cut so Kansas City's school system can continue its profligate ways. Our textbooks will last another year. Our teachers will go a sixth year without a raise. And while the kids in Kansas City are enjoying their TV and radio broadcast studios (including animation facilities), and their zoo facilities, and their art gallery, the Westboro school board will be up on the roof with a bucket of roofing tar.

Blake Hurst operates a farm and greenhouse in Missouri.

THE ARMS MAFIA

BY STEVEN W. MOSHER

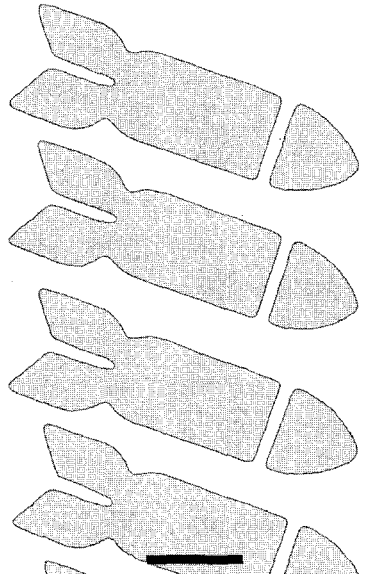
A senior Chinese military official, asked recently why his country sells missiles and other high-technology weapons to the volatile Middle East, cast a look of incredulity at the questioner. "For the money, of course," he replied.

But China's irresponsible arms sales are more than just an important source of hard currency for Beijing's empty government coffers. They are also a get-rich-quick scheme of the Communist elite. The scions of China's ruling families run the firms that sell arms, and the clans they represent siphon off a healthy percentage of the firms' profits.

These clans are extremely secretive, but some of their hidden connections to the arms-export complex have come to light. Poly Technologies Inc., perhaps the major arms-trading firm, is headed by Senior Col. He Ping, the son-in-law of Deng Xiaoping, China's senior leader. In 1989, company officials included Wang Xiachao, President Yang Shangkun's son-in-law; Wang Zihua, former Communist Party General Secretary Zhao Ziyang's son-in-law; and Wang Jun, Vice President Wang Zhen's son.

The Commission on Science, Technology, and Industry for National Defense, which oversees Poly Technologies Inc. and other international trading firms in the arms complex, is another plum perch for the elite's offspring. The family of China's only living marshal, Nie Rongzhen, dominates COSTIND. His son-in-law, Lt. Gen. Ding Henggao, is COSTIND's chairman, and his daughter, Maj. Gen. (Tech.) Nie Li, is deputy director of COSTIND's Science and Technology committee. Other COSTIND officials include Zhang Pin, son of former Defense Minister Zhang Aiping, and Ye Chumei, daughter of the late Marshal Ye Jianying. The Yang clan is again represented, this time by President Yang Shangkun's eldest son.

The world has gotten much more dangerous since China's great Communist clans abandoned their revolutionary calling and went into the arms business in the early '80s. Between 1983 and 1990, China signed weapons and lethal technology agreements worth more than $16 billion. Most of these agreements have involved the transfer of ballistic missiles and other high-tech weapons to Middle Eastern countries.



A secret U.S. Defense Intelligence Agency study circulated in 1991 concluded, in the words of one Bush administration official, that "it is the official policy of the Chinese government to covertly sell missiles to whoever can pay for them."

In 1991, the Chinese delivered M-11 series ballistic missiles to Pakistan. The M-11 is a mobile, intermediate-range, nuclear-capable missile comparable to the Soviet SS-23s that were recently removed from Europe. The Chinese are also reportedly setting up production lines in Iran for both the M-11 and the M-9, which has a longer range but a lighter payload than the M-11. This is part of a 10-year technology-transfer agreement between Beijing and Teheran, signed in 1990, that may also include nuclear-weapons technology.

There are few weapons in China's arsenal that this arms mafia won't sell. In 1988 and 1989, China shocked arms-control experts by secretly shipping CSS-2 East Wind missiles, with a range of about 1,200 miles, to Saudi Arabia. It was the first time one country transferred an entire intermediate-range ballistic-missile system to another.

To Pakistan, China reportedly provided the blueprints for a nuclear bomb and then handed over enough weapons-grade plutonium for its construction. A secret U.S. Defense Intelligence Agency study circulated in 1991 concluded, in the words of one Bush administration official, that "it is the official policy of the Chinese government to covertly sell missiles to whoever can pay for them."

After learning that COSTIND had agreed to sell M-9 missiles to Syria, last May the Bush administration imposed arms-related trade sanctions on China. The curbs included cutting off the sales of computers that could be used for missile control, barring cooperation in launching satellites, and placing an embargo on all high-tech exports to the Chinese front company that sold missiles to Pakistan.

These sanctions didn't deter China's clan-affiliated firms. Last August, reports the *Far Eastern Economic Review*, China delivered to Syria a shipment of the Transporter/Erector/Launcher equipment used with the M-9 missile. The mis-

siles themselves will probably follow sometime this spring.

Secretary of State James Baker ended a three-day visit to China in November by announcing that China had made important concessions on arms control. Stone-faced Chinese officials immediately disputed this claim, saying that they "may consider" signing the Nuclear Non-Proliferation Treaty and halting the overseas sales of missiles and related technology, but only if the United States cancels its newly imposed sanctions.

Considering China's record on weapons sales, as well as the clout of those involved in arms dealing, it is hard to take such promises seriously. On two separate occasions since last July, China has agreed to limit the proliferation of nuclear and conventional weapons, but the sales of these weapons continue. The efforts of American officials to persuade senior Chinese leaders to exercise restraint have fallen on deaf ears—not surprisingly, since their families' rice bowls are at stake. Given the millions of dollars of easy profits to be made from arms sales, continued duplicity and evasion of international responsibility by the Chinese seems likely.

As the Communist dynasty continues to decay, the problem may well grow worse. China's weapons mafia knows that it will one day be replaced by a democratic, free-market regime. The temptation of the men and women who run Poly Technologies Inc. and COSTIND is to take the money and run.

But run where? Perhaps the best way to encourage them to behave responsibly is to deny them sanctuary. William Tiplet II, a senior staff member of the Senate Foreign Relations Committee, argues that we and our allies should "very quietly inform the clans that, come the democratic revolution in China, they won't find refuge in the West if they have contributed to the nuclear arming of Middle Eastern dictators."

Contributing Editor Steven W. Mosher is the author of China Misperceived: American Illusions and Chinese Realities *(Basic Books).*

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Israel's "Right to Exist"

Is it important that the Arabs acknowledge it?

The Israelis wanted the second phase of the Mideast Peace Conference to convene in the respective capitals of the involved parties. It seemed like a reasonable suggestion. After all, Jerusalem is only 150 miles from Damascus, Syria, and only 80 miles from Amman, Jordan. But the Arabs, did not accept that suggestion and insisted on a site as far away from home as possible. Why would they wish to impose such inconvenience on themselves? They believed that meeting with Israel in their respective capitals might by inference be considered as their recognition of Israel's existence.

What are the facts?

■ Despite decisive military defeats in the wars that they have launched against the Jewish state since the very day of its birth, the Arabs, in an almost unbelievable act of mental acrobatics, deny the existence of the country that has inflicted such severe and repeated punishment on them. When it becomes inevitable to mention the Jewish state it is referred to only as "the Zionist entity".

■ This non-acknowledgement of Israel's existence is not simply a matter of semantics. Arab maps do not show Israel, but a vast area, including Jordan, labeled as "Palestine". Cities such as Tel Aviv and Haifa simply don't exist. Arab school children, though imbued from earliest age with hatred of the Jews, have no "official" knowledge of the existence of Israel. They learn about it, one supposes, just as they learn about sex, by whispered comments in the schoolyard. Schedules of foreign airlines that show Israel on their route maps or that list Israeli destinations are not allowed in the countries. Foreign publications (among them, one regrets to report, such U.S. magazines as *Time* and *Newsweek*) print special editions for the Arab countries, since no publication carrying advertising of Israeli firms may appear in those countries. And, of course, tourists of any nationality may not enter most Arab countries if their passports shows evidence that the holder has ever visited Israel, the "non-existent country". Not too many months ago, a U.S. Senator was barred from entering Saudi Arabia, our "faithful ally", because of an Israeli visa stamp that had been placed in his diplomatic passport.

■ As an inducement to Israel for yielding land that is absolutely indispensable for the country's defense, the Arabs now and then offer the possibility of the "recognition" of Israel's existence. The sad and almost incomprehensible aspect of that is that many well-meaning people in the U.S., in other countries, and, yes, even in Israel believe that this might be an acceptable bargain for Israel. But Israel's existence is in no way dependent on the recognition of any Arab state. It's simple: Israel exists because it exists. Therefore, supposing that any meaningful face-to-face meetings came about and if, say, a Syrian diplomat should ask Israel what it would be prepared to "give" if Syria would consider acknowledging Israel's existence, Israel should reply that Israel might in turn consider acknowledging *Syria's* existence. Or, Israel could declare a boycott of the Arab world and could offer to relax or to rescind such boycott in consideration of parallel gestures by the Arabs.

The bizarre concept of Israel's "non-existence" has been around for over forty years. Many good people, including quite a few in Israel itself, have been led to believe that Israel should bring substantial sacrifices, even to the point of imperiling its own security and survival, in order to get the Arabs to acknowledge Israel's existence. It is often said that Israel needs to be "recognized" by the Arabs in order to "normalize her condition". But need not the Arabs, too, live in "normalized conditions"? And Israel is often promised that, in return for yielding vital strategic territory to the Arabs, she would be assured of "safe and secure borders". But don't the Arabs also need borders that are safe and secure? The Arab countries and much of the world have come to believe that peace is only good and desirable for Israel. But it is surely at least as important for the Arabs, who have lived through and have been bloodily defeated in five wars with Israel – the "non-existent country". Peace and prosperity can and will come to this troubled region only when the Arabs accept the reality of Israel's existence and negotiate with her openly and in good faith.

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Head of the Class

BY JOHN HOOD

We Must Take Charge: Our Schools and Our Future, by Chester E. Finn Jr., New York: The Free Press, 365 pages, $22.95

Last year's publication of *Politics, Markets, and America's Schools*, written by John Chubb of the Brookings Institution and Terry Moe of Stanford University, had more impact on the education reform debate in the United States than virtually any other event or publication in recent memory. It was an important book, not only because of its intrinsic worth—its tightly reasoned arguments in support of parental choice and its distillation of dry academic research into an understandable form—but also because of an extrinsic fact: Its publisher was the Brookings Institution, Washington's venerable liberal think tank, which in a stroke transformed the choice cause into a bipartisan, ideologically neutral one.

In the same way, Chester Finn's *We Must Take Charge: Our Schools and Our Future* offers the possibility of advancing the reform debate to a higher level. It's also an important book. First, both intrinsic and extrinsic factors make Finn's book invaluable in understanding the Reagan and Bush administrations' education reform agendas. "Checker" Finn, who served in the U.S. Education Department under Secretary William Bennett, provides an insightful (if perhaps excessively glowing) account of Bennett's tenure and of the policy-making team that so angered Democrats and the education establishment in the 1980s.

Indeed, Finn's history of education reform since World War II, starting with school desegregation and the rise of the Sputnik-era "education essentialists" and ending in the "excellence" movement of the 1980s, provides a critical backdrop for understanding education policy today. Furthermore, the book provides supporters, opponents, and casual observers (if there are any) of federal education policy the opportunity to dissect the opinions of a major official of the Reagan administration and a chief adviser to Education Secretary Lamar Alexander.

Finn provides evidence that more spending on education won't necessarily make any difference and that class size is not a significant determinant of educational success.

Second, the book is important for reporters, candidates, and debaters of education reform everywhere. In a masterful chapter titled " 'How About a Marshall Plan for the Schools?' and Other Talk-Show Explanations of Educational Meltdown," Finn trudges through the all-too-familiar terrain of popular education mythology, successfully debunking nostrums and summarizing education research.

He provides evidence for the propositions that more spending on education won't necessarily make any difference, that class size isn't a significant determinant of educational success (except at sizes of five students or fewer), that expanding Head Start isn't a magic bullet, that all American students—not just those "at risk"—are performing poorly, and that equalizing school spending among districts won't necessarily reduce gaps between rich and poor, since some of the worst school systems, especially those in urban areas, already receive more funding per pupil than their rural counterparts.

Third, the book is important for those already part of the "conservative" movement or who support, as does Finn, market-oriented reforms such as parental choice. Finn repeats education writer Lawrence Uzzell's insight that conservatives can be divided into "neocentralists" and "neopluralists" according to their views on education.

Neocentralists (who, by the way, are often neoconservatives) believe that public schools serve to transmit culture, integrate society, and facilitate democracy. They want to prepare people to be good voters and parents. They support a nationwide core curriculum as well as nationwide and uniform testing of students (and perhaps teachers).

Neopluralists (who are often libertarians), on the other hand, tend to emphasize the primacy of parents, the benefits of competition, and the inefficacy of government regulations. They focus on preparing people for the workplace. They support vouchers, deregulation, and curricular (in addition to operational) diversity among even publicly funded schools. Finn argues that neither of these two positions, each ideologically consistent internally and therefore comfortable, will suffice. His plan combines elements of both, which he says is more difficult to do but ultimately more productive. But in fact, Finn is at heart a neocentralist, albeit a moderate one. His arguments for and discussion of a national, comprehensive testing program dominate the book.

As a moderate neopluralist, I can't resist challenging a couple of his major

points on testing. First, Finn argues that efficiency as well as probity dictates a single, national test. Certainly his critique of existing standardized tests, with their skewed results and incomparability, is right on target. And in a chapter entitled "Rational Fools: What's In It for Me," Finn convincingly demonstrates that only by making student achievement matter in the adult world, by making tests ubiquitous and necessary for college admission or employment, will education reform really change students' attitudes about their own schooling.

But these arguments don't prove the need for a federally administered test. Competing tests and testing companies would seem to be able to achieve what Finn desires, with the added advantage of creating a competitive rather than monopolistic situation. Neocentralists might respond that competing tests won't drive the system toward the unified core curriculum we really need. But the general requirements of a core curriculum—excellence in math, science, history, literature, and writing—would be shared by competing tests. What isn't so amenable to easy standardization is the choice of facts to be included or methods employed to teach them.

To employ Finn's practicality paradigm, it's relatively easy to come up with a serviceable test of math, science, and communication skills for use by employers, since test designers have a clear feedback loop from employers about what is important and what is not. But how do we decide whether a potential parent or voter needs to know more about Whitman or Longfellow, the battle of Saratoga or the battle of Cowpens, quantum mechanics or biochemistry?

Both in the construction of test questions and in the development of school curricula, it is necessary to make tradeoffs. After all, there are only so many minutes in the school day (something else Finn as neocentralist would change). Short of requiring a certain score on the national test for people to become voters or parents, neocentralists lack an easy guide for constructing curricula and tests to achieve their lofty objectives. That doesn't mean one can't aim to achieve those objectives, but what it suggests is that different educators might design different ways to do it. Why not let schools and parents choose between them?

A second point, related to the first, concerns Finn's contention that reformers need to abandon the old commitment to "local control." Reform in the '80s and '90s, he insists, will move education decisions either up to the state level (where the action has been in the last decade) or down to the school level, leaving local authorities such as school boards with little to do.

This is certainly true in theory, but unfortunately in practice parents and reform-minded educators still need a safety valve. It's all too easy, as Finn himself reports throughout his book, for the education establishment to seize control of state or national initiatives. If local systems can still chart their own course, they can end-run recalcitrant or downright villainous state officials, union leaders, or legislators.

Let's put it this way: If Checker Finn were drawing up a state test or a state curriculum, there would be no need for "local control"—in fact, it would be counterproductive if it thwarted the implementation of his program. Unfortunately, the prospects for sensible state or federal school governance aren't so rosy. Maybe Finn's book will change that by making established interests in education and politics rethink their own faulty and squishy views about knowledge and learning. Maybe. That would make it an even more important book.

Contributing Editor John Hood is editor of Carolina Journal, *published by the John Locke Foundation in Raleigh, North Carolina.*

The Bottle in the Gene

BY STANTON PEELE

Alcohol and the Addictive Brain, by Kenneth Blum, with James E. Payne
New York: Free Press, 320 pages, $24.95

According to a Gallup poll, the overwhelming majority of Americans (about 90 percent) believe that alcoholism is a medical disease. Schools teach children the disease theory as scientific fact, and the news media take it for granted. For Kenneth Blum and James E. Payne, authors of *Alcohol and the Addictive Brain*, the disease theory of alcoholism is only a starting point. Blum, a University of Texas pharmacologist, and Payne, executive director for the National Foundation of Addictive Diseases, seek to demonstrate not only "that alcoholism is a biogenetic disease characterized by genetic anomalies" but that a wide range of excessive behavior can be traced to a similar defect.

Blum's claims about the amino-acid-and-vitamin mixtures he markets for treatment of alcoholism, cocaine and heroin addiction, and obesity are based on the idea that all addictions stem from the "addictive brain" in the book's title. Blum says his supplements compensate for the depletion of neurotransmitters such as dopamine, an abnormality that he claims marks alcoholics, addicts, and obsessive eaters.

Dopamine figures prominently in Blum and Payne's effort to formulate a "neurogenetic theory of compulsive disease." They argue that a special need for dopamine stimulation is caused by what they call the "pleasure gene," which limits the natural intake of dopamine and, therefore, the ability to achieve pleasure. People thus afflicted must pursue "abnormal pleasure-seeking activity," leading not only to alcoholism and heroin addiction but to "other compulsive diseases such as cocaine abuse, food disorders, gambling, and sexual promiscuity."

This theory seemed to receive a boost in 1990, when Blum and psychiatrist Ernest Noble identified a defect in the dopamine D2 receptor gene as the common thread in alcoholism. Examining the

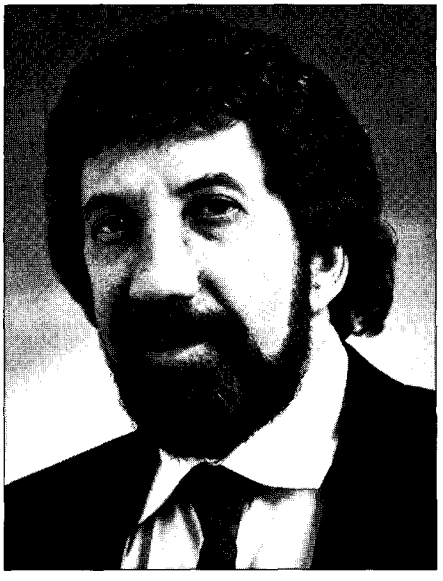
brain tissue of 70 dead subjects, half of them alcoholics, Blum and Noble found a variant of this gene in 69 percent of the alcoholics but only 20 percent of the nonalcoholics. This finding, published in *The Journal of the American Medical Association*, received nationwide publicity and was trumpeted as the discovery of the "alcoholic gene."

Several subsequent studies, however, failed to find such a remarkable occurrence of the gene defect in alcoholics. Two studies published in *JAMA* after Blum and Noble's paper found little or no relationship between alcoholism and the D2 receptor gene. Other studies have found a relationship weaker than the one measured by Blum and Noble. A study reported in the October 2 issue of *JAMA* found that the gene variation occurred in people with several disorders—including Tourette's syndrome, hyperactivity, and autism—at least as often as in alcoholics.

This finding runs counter to the "addictive brain" theory since people with autism or Tourette's syndrome are not thought to be especially pleasure seeking. No study has found that members of a family who become alcoholic are more likely than nonalcoholic family members to have the gene variation, which is the conventional test for establishing a genetic cause of a disease.

So Blum and Noble's dramatic finding turns out to be far less credible than originally believed. Nevertheless, the impression that scientists have identified the genetic basis for alcoholism remains widespread. This misperception is typical of a general attitude that exaggerates the significance of research pointing to genetic or biological factors in alcoholism, ignores caveats and qualifications, and overestimates the consensus within the scientific community. Blum and Payne, for example, imply that opposition to the disease model is limited to "a few psychologists [among whom I am numbered] and a philosopher, who ignore the vast body of research findings over the past four decades."

But the "addictive brain" theory faces opposition from genetic and medical researchers as well. A leading American behavioral geneticist, Robert Plomin, says: "A.A. wants it to be a genetic disease," but "the evidence isn't all that convincing." Canadian physician and pharmacologist Harold Kalant, the researcher most identified with discovering the basic biological properties of excessive drinking, says that "alcoholism is now seen as a disorder of behavior, rather than a metabolic disease caused by something which obligatorily makes a person drink." In this view, genetics may influence an individual's biological reaction to alcohol, but this reaction is not the same thing as alcoholism.



Kenneth Blum argues that bad habits can be traced to a "pleasure gene."

Instead, Kalant says, it is necessary to focus "on the social and individual controls that normally keep drinking within healthy bounds, and on the factors which remove those controls." In other words, since an inexorable craving for alcohol is not inherited, whatever sensations alcohol does produce for the individual must be balanced against his or her values, expectations, and social milieu, which either encourage or discourage repetitive intoxication.

This view jibes with the findings of psychologists and sociologists. A great deal of evidence, more consistent and extensive than anything yet established by biological research, shows that social categories are the best predictors of drinking problems and alcoholism. For example, in one study of Boston ethnics, Irish Americans were seven times as likely to become alcoholic over a 40-year period as Italian Americans living in the same neighborhoods. Research uniformly finds alcoholism to be 3 to 10 times as prevalent among men as among women. Even researchers with a biological orientation acknowledge that group differences of such magnitude cannot be explained by genetic factors; certainly no such genes have been identified.

Psychological studies also find a strong connection between problem drinking and individual beliefs about alcohol. For example, research shows that alcoholics believe alcohol has a greater impact than do nonalcoholics. Longitudinal studies find that expectations about the powerful and beneficial effects of alcohol predict problem drinking even when measured in preteens who have not yet begun to drink.

Furthermore, the medical and research communities are split over the wisdom of classifying excessive behavior other than alcoholism and drug abuse—such as overeating, gambling, and sex and love addiction (or codependence)—as diseases. Many biological scientists find it difficult to imagine that a single mechanism could encompass such a wide range of human behavior. In their view, to call gambling, sexual excess, overeating, and alcoholism versions of a single addictive process is to eliminate the possibility of a biological cause.

Blum and Payne obscure differences among competing genetic and biological theories of alcoholism, giving the false impression that biological researchers are working toward identifying a single source of excessive drinking. While they cite favorably the work of Henri Begleiter of Downstate Medical Center in identifying anomalous brain waves in alcoholics and their offspring, for example, such work really has no bearing on dopamine theory. Begleiter is one of many genetic investigators who has not endorsed dopamine as an important factor in alcoholism.

Blum is notable among those exploring the role of genes in alcoholism for his enthusiastic support of Alcoholics

"Two thumbs up."

At the seminar:
—David Nickoll, Williams College, and David Yagobian, Antioch College

Peter Pruce, a Los Angeles screen writer, sparked questions from students participating in the 1990 Liberty in Film & Fiction seminar.

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Anonymous. A large part of *Alcohol and the Addictive Brain* reviews the 12 steps of A.A. and such faddish movements as adult children of alcoholics (ACoA). A.A. is in many ways the progenitor of the 20th-century disease view of alcoholism, but it seems strange that a spiritual fellowship and medical research should fit together like hand and glove, as Blum and Payne repeatedly insist they do. Yet wedding these two odd bedfellows allows Blum to market his products more effectively to treatment centers and to gain support among A.A. members.

But if, as Blum claims, genetic discoveries will bring tremendous progress in fighting alcoholism, prayer will no longer be the primary treatment for the disease. Alcoholics might even be able to drink normally once their flawed, addictive genes are modified (a futuristic procedure Blum describes) or when the chemical imbalances the genes cause are remedied by drug therapy. This inherent conflict between A.A. and medical approaches leads Blum and Payne, on the one hand, to attack those who question the disease theory and think "alcoholism can be arrested, and often cured," and, on the other, to predict that "the next forty years will bring cures...for compulsive diseases such as alcoholism, drug addiction, and food disorders."

In reality, we are so far from even imagining a biological cure for alcoholism that purported genetic discoveries serve only to reinforce the idea that excessive drinking is a disease. When genetic screening techniques become precise and cheap enough, we may be able to tell adolescents they have genes that investigators like Blum think predispose them to alcoholism. But what should they do with this information? Even by Blum's account of the genetic contribution to alcoholism, most of these teens will not become alcoholics. And psychological research finds that the expectation of losing control over alcohol consumption is often a self-fulfilling prophecy. So such a genetic early warning system is likely to produce more problem drinking than it prevents. This is surely a cure that is worse than the disease.

Contributing Editor Stanton Peele is a psychologist specializing in addiction research.

Hard Times in the Land of Plenty?

BY RONALD BAILEY

America's Renewable Resources: Historical Trends and Current Challenges, edited by Kenneth Frederick and Roger Sedjo, Washington: Resources for the Future, 296 pages, $34.95/$19.95 paper

American forests are rapidly shrinking before the onslaught of clear-cutting corporations; irreplaceable topsoil is eroding away at alarming rates due to heedless exploitation; the remnants of America's once-abundant wildlife are on the verge of extinction; ranchers are overgrazing the West's fragile rangelands, turning them into an American version of the Sahel; our cities will soon die of thirst as we run out of fresh water. All true statements, right? Wrong!

In fact, America's renewable-resources situation has improved dramatically since World War II. But because of all the misinformation peddled by leading environmental organizations and the mainstream press, most Americans believe that they live in the midst of accelerating environmental decline.

Resources for the Future, an environmental think tank, has published a valuable corrective to the conventional wisdom of doom that pervades our national discussion of natural resource and environmental issues. The book, *America's Renewable Resources: Historical Trends and Current Challenges*, also points out how the provision of secure private property rights significantly contributes to improved resource protection and management.

The best news is about our forests. "By most criteria, U.S. forests are in excellent condition," argues Roger Sedjo, head of RFF's Forest Economics and Policy Program.

Since 1920 U.S. forests have expanded from 600 million acres to 728 million acres. Why did this happen? Prices.

Millions of acres of farmland abandoned because of advances in agricultural productivity and the elimination of pastures used to feed draft animals have returned to forests. Higher real prices of timber also led to the development of new methods for harvesting and preserving wood. By 1950, improvements in wildfire control made plantation forestry economically attractive. Now forest area in New England, the South, and the Great Lake states is substantially greater than it was in the mid-19th century.

Forest regrowth took place while the U.S. population doubled and GNP increased sixfold, undercutting the conventional view that increased population and economic growth must lead inexorably to the destruction of a natural resource base.

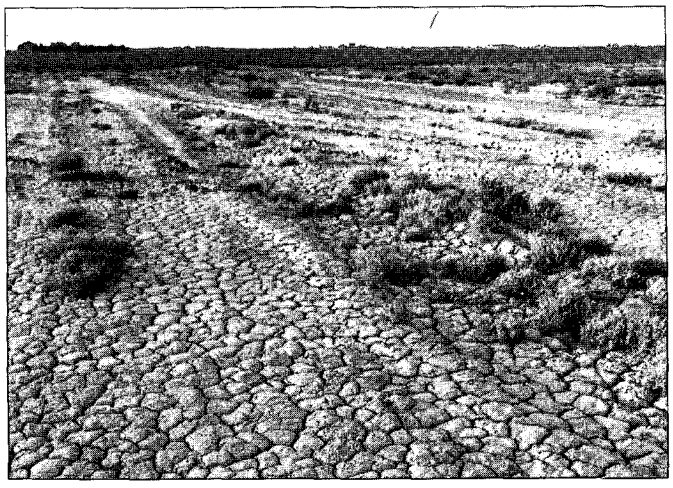
Claims by such alarmists as the Worldwatch Institute's Lester Brown that the United States is losing its precious topsoil also turn out to be exaggerated. The assertion that for every ton of wheat harvested three tons of topsoil are lost aired last year on the public television series *Land of the Eagle*. It's not true.

The "topsoil crisis" has deep historical roots. In 1928, a U.S. Department of Agriculture bureaucrat, Hugh Hammond Bennett, published an apocalyptic tract declaring that tens of millions of acres of cropland were "devastated" and "totally destroyed" by erosion. Eventually, as chief of the new Soil Conservation Service, Bennett claimed almost half of the United States' 415 million acres of cropland were severely eroded.

"It may be accepted that over the past fifty years the threat of erosion to permanent losses of soil productivity was never as great as many people claimed," concludes RFF soil expert Pierre Crosson. He points out that U.S. crop productivity

would be much lower if soil erosion rates were as bad as claimed. In addition, since plant roots are the main source of organic material in soils, modern high-yield crops, with their greater quantity of roots, may actually restore productivity.

And what does it mean to say that eroded soil is "lost"? The National Research Council says the practice of using erosion estimates as measures of "soil loss" is wrong. Soil is moved or displaced—it isn't lost. Soil that leaves one farm is far more likely to end up on another farm than to flow to the ocean.



Environmentalists say irreplaceable topsoil is eroding away at alarming rates. Soil experts disagree.

Crosson contends that "present rates of erosion throughout most of the next century would pose no serious threat to the productivity of the nation's soils." He estimates that even with no improvements in agricultural technology crop yields would drop by a minuscule 2 percent over the next century. Some crisis, huh?

And who hasn't heard that due to suburbanization we are losing prime cropland? This farm-conversion crisis started in 1977 with a badly done federal government survey that claimed the United States was losing nearly 3 million acres per year to development. Later studies showed perhaps 30 million acres of the country's 570 million acres of farmland would be converted by the year 2030.

"Twenty-five years hence game in North America in the wild state will have ceased to exist," predicted a leading naturalist in 1904. The turnaround in the fortunes of wildlife resulted from the elimination of government bounties on many species, the renewal of the forests, and the effective legal protection of animal species in the wildlife commons.

The numbers of wild geese, trumpeter swans, wild turkeys, egrets, and white herons are growing. Pronghorn antelope have increased from a low of 13,000 to more than 1 million; white-tail deer are up from 350,000 to more than 20 million, making them more numerous than ever before; the elk herd has grown from 41,000 to more than 1 million; wild bison have multiplied from 800 to 6,000; northern fur seals have increased from 215,000 to 1.5 million; sea otters have returned to their historic ranges; and beavers are now more numerous than ever before.

Rangeland expert Marion Clawson says that "on the whole western rangeland is in better condition today than at any time during the twentieth century." Agricultural economist Delworth Gardner notes that "the environmental community has strongly condemned overgrazing, although it has never produced convincing proof that overgrazing is creating deteriorating range conditions." Experts expect forage production on rangeland to increase 47 percent by the year 2040.

Supplies of fresh water aren't a problem, but water misallocation is a problem, especially in the West. Irrigated farms consume more than 90 percent of the water in the West and, on average, the federal government subsidizes 80 percent of the construction costs of irrigation projects. Regarding groundwater, RFF Renewable Resource Director Kenneth Frederick writes, "Economic factors will reduce and then eliminate groundwater mining long before the water in an aquifer is exhausted." Farmers respond to incentives like anyone else. Once it costs too much to pump water from a declining aquifer, the land is no longer irrigated.

U.S. surface-water quality deteriorated until the 1960s, when pollution-control measures began to improve the situation. Today, 72 percent to 95 percent of America's lakes, rivers, and estuaries are fishable and swimmable.

To correct misallocation, Frederick recommends marketing secure and transferable property rights to water. He also argues that marketable discharge permits would encourage the development of new, cost-effective pollution-control technologies.

Filled with high-quality information and thoughtful analysis, this book is a good antidote to orthodox environmental doomsaying.

Ronald Bailey, currently at the Cato Institute, is writing a book on apocalyptic environmentalism for St. Martin's Press.

Barbs and Bards

BY CRAIG COLLINS

A Line Out for a Walk, by Joseph Epstein, New York: W.W. Norton & Company, 331 pages, $21.95

No contemporary essayist quite fills the void left by H.L. Mencken. None is so thoroughly atheistic when it comes to political orthodoxies.

The American Spectator's Bob Tyrell comes close, but he speaks to an intellectual audience. Mencken spoke more to the "motormen's wives." P.J. O'Rourke can be hilarious, but he sometimes sacrifices common sense for humor, which Mencken would never do. To truly satisfy a hunger for Mencken's style of witty, well-written social comment, readers must mix a bouillabaisse of the best works from all these and other writers.

To that broth, Joseph Epstein adds some spice with flawless prose and keen observations. His weakness is that he

USDA SOIL CONSERVATION SERVICE

seems too nice to exhibit Mencken-quality curmudgeonliness, though anyone who provoked Joyce Carol Oates into demanding his resignation deserves some credit.

In this collection of essays, Epstein honors Mencken's memory by taking a few jabs at modern-day prohibitionists (the antismoking fascists) and puritans (the political-correctness crowd). He refers to himself jocularly as a "Jewish anti-Semite" and claims to be speaking "in my capacity as chairman of the Committee to Re-establish Stereotypes Built on Gender." After speculating on the different gambling proclivities of various ethnic groups, Epstein thoughtfully adds, "Various anti-defamation leagues—Chinese, Black, Jewish, Italian, Irish, Texan, Rumanian—wishing to protest this paragraph may reach me at my office, care of the director, Center for Advanced Ethnic Insensitivity." Mencken must be smiling in his grave.

None of his comments are really insulting, though Epstein doesn't mind a good put-down. Indeed, one of the essays lauds the perfectly aimed barb. He lists examples from the usual suspects—Oscar Wilde, Dorothy Parker, Winston Churchill—but the highly literate Epstein has a sufficiently firm grasp of the esoteric to include novelist Josephine Herbst's claim that critic Leslie Fiedler looked "like one of those soft people in Turgenev."

Epstein pontificates in like fashion about the sweet taste of juicy gossip and the thrill of fame, and he offers "a few kind words for envy"—all of this without any trace of de rigueur guilt about what are, after all, character flaws.

An Epstein essay is like a conversation with an average guy, assuming the average guy has a gigabyte of literary anecdotes stored in his brain. Almost every essay includes a parade of historical figures, from the famous to the obscure, who step on stage long enough to deliver a clever quote and then move along.

In the piece on envy, we hear from Herman Melville ("Well, though many an arraigned mortal has in hopes of mitigated penalty pleaded guilty to horrible actions, did ever anybody seriously confess to envy?") and Horace ("Sicilian tyrants could never have contrived a better torture"), and we learn that Orwell called envy "a horrible thing [which] is unlike all other kinds of suffering in that there is no disguising it."

If name-dropping were a crime, Epstein would be facing 20 years to life. In the piece on gossip alone, the cast of characters includes: Salman Rushdie, Rushdie's American wife, Dante, Fidel Castro, Evelyn Waugh, Stendahl, Jackie Onassis, writer Isaac Rosenfeld, John Dewey, Wittgenstein, Sidney Hook, Bertrand Russell, Justice Holmes, Harold Laski, Sir Frederick Pollock, Lewis Einstein, the Duc de Saint-Simon, Louis XIV, Henry James, Marcel Proust, E.M. Cioran, the Rev. Sydney Smith (founder of the *Edinburgh Review*), Lady Mary Bennet, Lady Grey, Lord Grey, J.A. Murray (who worked on the *Edinburgh Review*), Lady Caroline Lamb, Lady Ilchester, and Lord Byron.

Epstein favors public funding of art but doesn't consider it a right. As a member of the National Council for the Arts, he summed up the attitude of grant recipients: "We're the cutting edge. You buy the scissors."

Epstein is a compulsive quoter. One might be tempted to explore the implications of this. Is Epstein endeavoring to display his intellect? Is he merely living off the wisdom of others? What defines a good quote? Should a quote be fresh rather than pithy, if it can't be both? The answers to these questions could be the subject of a very good essay about Epstein. In fact, this essay has been written by Epstein himself. He included it in this collection ("Quotatious") in a self-analytical preemptive strike that doesn't seem entirely fair to marauding book reviewers.

Having collected the literary equivalent of sound bites for years, Epstein makes an occasional and usually transparent effort to manufacture his own memorable bon mots. Sometimes he succeeds rather nicely.

In an essay unfortunately not in this collection, Epstein knifed local politicians when he said his native Chicago "remains a city that stands in refutation of Lord Acton's maxim by demonstrating, again and again, that only a small amount of power can corrupt absolutely."

In this collection, Epstein displays his talent for metaphor (construction workers near his home "appraise passing young women with a jeweler's eye and a burglar's conscience") and for a good opening line ("Unlike every other paragraph I have written in my life, this one I am writing while wearing a red fez"; how could one not read farther into this playful piece about hats?).

Some of his lines are quite funny. When describing his gastrointestinal brush with mortality, he says his doctor "put me through an examination that steadied me in my already firm resolve to spend all my days as a heterosexual."

Some don't quite click. In an essay about his height, he says that "one of the nice things about having been Napoleon (5′ 2″) is that at least no one could ever accuse you of having a Napoleonic complex."

For anyone who loves words and loves to read, Epstein's work is entertaining. But the stylish exterior of these essays masks a deeper...nothing. There's not much to them in the way of insightful comment or fresh analysis even about the simple things in life, such as confronting a social bore or buying a new hat. Each essay is a tale told by a clever writer, "full of sound and fury, signifying nothing." (Hey, he who lives by the quote, gets reviewed by it.)

This is a bit of a disappointment. Epstein is best known for his literary criticism, and at that he excels. He is editor of

The American Scholar, the quarterly publication of Phi Beta Kappa, the academic honor society. Two of his previous books, *Partial Payments* and *Plausible Prejudices,* collect some of his best critical pieces. He claims to read on average five hours a day, and the wealth of knowledge he has accumulated is well reflected in these analyses of contemporary authors.

Epstein's efforts have made him an expert on form but not on substance. He admits in a personal essay in this collection that he "would rather read a stylish book than a style-less more scholarly book on the same subject." This habit has polished his wit but possibly impoverished his knowledge. He can quote widely from Milton (neither Berle nor Friedman, he adds helpfully) to Butch Cassidy and the Brothers Goncourt, and he writes with zing but with little intelligent or original thought.

Politically, Epstein probably should be classified as a neoconservative. A member of the National Council for the Arts (the group that advises the chairman of the National Endowment for the Arts), he has favored government subsidies for artists but denied that not funding someone is the equivalent of censorship. Characteristically, he chided grant recipients with this quotable assessment of their position: "We're the cutting edge. You buy the scissors."

In writing elsewhere against the oppression of political correctness, he made a humorous reference to "Dykes on Bikes," which he claims is a regular participant in San Francisco's gay rights parade, and repeated a joke likening feminists to pit bulls in terms of humorlessness. Joyce Carol Oates immediately wrote a letter to *The New York Times* describing Epstein's resignation from *The American Scholar* as "long overdue."

Literary comment, rather than social comment, is Epstein's forte. He should stick to it (though he has just published a collection of short stories that may be worth a look). He should, to borrow his words, be content to indulge his "strange passion for acquiring the knack of writing interesting sentences."

Craig Collins lives in Los Angeles.

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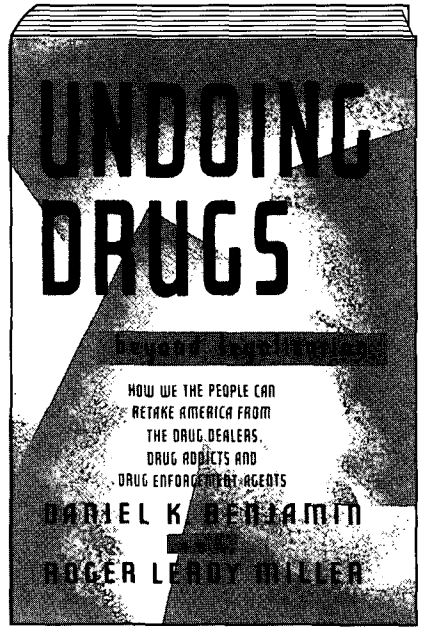

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THE MORNING AFTER

BY THOMAS W. HAZLETT

Let's try to get a handle on the situation. For 45 years, we Americans engage in a very scary international poker game—called "brinkmanship" on History 106 midterms—with a truly rotten bunch of Soviet thugs prone to torturing civilians and butchering whole cultures. Our ace in the hole in this match is MAD—Mutual Assured Destruction. The big shots in the USSR wouldn't push the button and vaporize 36 billion pounds of American flesh because we would just incinerate similar tonnage on their team.

This was not one of your better spectator sports. Even the luxury boxes were on the (bloody) field of play. Then poof—without firing a service revolver—we win. A nuclear holocaust is defused. No more nail biting over the Big One. Whew, what a relief that is. And it ought to at least shut up all those whiny, tiny school tots who were bawling to their third-grade teachers about how they couldn't sleep for weeks following the hit mini-series *The Morning After* back in 1984.

My olfactory senses indicated that the morning after the Cold War smelled just fine. It was considerably cooler than 382 degrees Fahrenheit, which is what I recall the movie version predicted for this day. There wasn't much of a rush to the bomb shelters, and parking wasn't any more of a problem than usual. This, to me, is excellent news.

Yet America is hardly jumping for joy, let alone tossing ticker tapes for Boris the Liberator. Recent surveys of the U.S. public chart plummeting spirits. At our moment of greatest glory we feel ill. This can only be a virulent national attack of PMS: Post-MAD Syndrome.

One of the greatest ironies of politics is that past victories count for much less than future promises, despite the fact that no one believes the promises. The Bush administration is even taking a beating for being overly concerned with foreign affairs: OK, so you won the Cold War and thwarted thermonuclear extinction; you've been neglecting *America*. Big deal if the Democrats are dwarfs upon the world stage—those problems are solved. (Don't expect the savvy Democrats to make a similar tactical error by actually solving a social problem in any of the cities or states they control.) For better or for worse, success makes one superfluous, as Winston Churchill discovered in post-WWII Britain.

And as Mikhail Gorbachev has now discovered in the ex-Soviet Union. Remember how Gorbachev got himself on the slippery slope to unemployment? He thought that Communism was being subverted by cocktails and corruption and that, along with some pep talks from the Premierski, a more open and honest press would clean things up.

But once *glasnost* legalized telling the truth, the USSR was well on its way to becoming the UFFR—the Union of Fewer and Fewer Republics. Because Gorbachev actually believed all the official propaganda on Marxist-Leninist dialectical inevitability and the ultimate superiority of socialism, he had no idea that liberalization was so fundamentally subversive.

No previous Soviet leader had been so naive. Lenin became cynical even before assuming power, jettisoning traditional civilities so heartily that Stalin's party purges were merely linear extrapolations. The utopian promises of collectivism became the domain of the Ministry of Information and were last taken seriously by the Soviet leadership sometime around October 1917.

Until Gorbachev. He was hooked so solidly that the party hacks could actually kidnap him and threaten both his life and that of his wife, and upon his escape he could only promise better, truer Communism.

By then Boris Yeltsin was empowered to swipe the mike from Mikhail and read the new script being written by history. To this day Gorby hasn't gotten it. Too bad for him; swell for us. The very first Communist to rule the USSR believed so fervently that he failed to invoke sufficient terror to maintain it: Why waste bullets—and look bad in the partly independent press—to shore up the inevitable?

Ironically again, Mikhail's wild reception in the West further served to sabotage the USSR, whose commander was actually proud of its ideology and sought not to tarnish its repute. (Thus, a humanitarian case for faking Gorbasm.) Gorbachev's reign was marked by a notable embarrassment about sending in the tanks; soon he was reduced to sending in the clowns.

I suspect that the nuclear freeze fanatics (SANE, Cranston for President, the Campaign for Nuclear Disarmament, etc.) from '83 and '84 were less frightened by young children not sleeping at night than they were of Ronnie Raygun (as they cleverly used to mock our president) being re-elected. But if their worst fears were realized, their best-advertised ones were not.

The 20th century has been generously hospitable to despots and tyrants who employed the tools of the modern age for cruelties and genocides never before possible. The human race has now been given a reprieve.

The outbreak of world peace doesn't mean that human misery has been eradicated, the business cycle slain, or personal tragedy vanquished. It does mean that the probability of millions of innocent human beings dying from nuclear MADness has been drastically reduced. I don't know what you were expecting out of 1991, but I'm going to call it a pretty damn good year for mankind.

Contributing Editor Thomas W. Hazlett teaches economics and public policy at the University of California, Davis.

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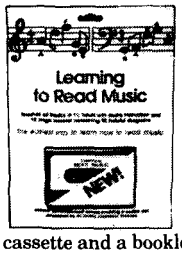

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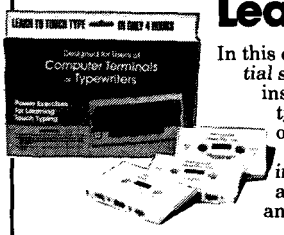

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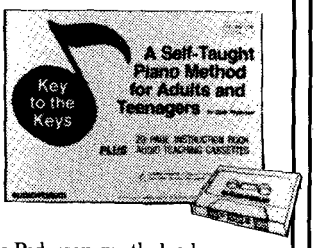
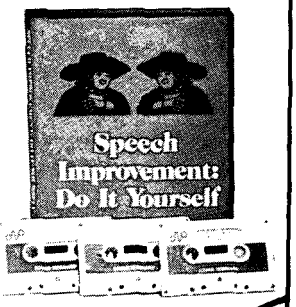


Deep down inside, almost everyone wants to know how to play the piano — the instrument of family songfests, parties, and intimate gatherings. If you've had the yearning but don't want to (or can't) take lessons, *Key to the Keys* is for you. It's a self-taught piano method that you can follow at your own pace and your own convenience. Author/teacher Gale Pederson gently leads you step by step, and you play chords from the beginning, which is lots more fun than picking out single notes. Order #S01550, $15.95.

Learn to Improve Your Speech



Accept compliments on your beautiful speaking voice after learning from this course, designed to correct the most common causes of unpleasant American speech. Professional speech tutor Phyllis Rooder-Weiss shows you how to diagnose your speech to pinpoint those elements that need improvement.

At a fraction of the cost of private lessons, you will learn how to:

- Correct nasality and build resonance
- Project your voice properly to be heard
- Achieve clear and distinct delivery of words
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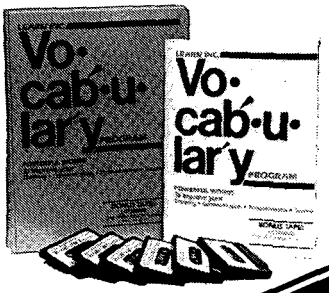
- Overcome mannerisms distracting to oral expression
- Achieve pleasing pitch

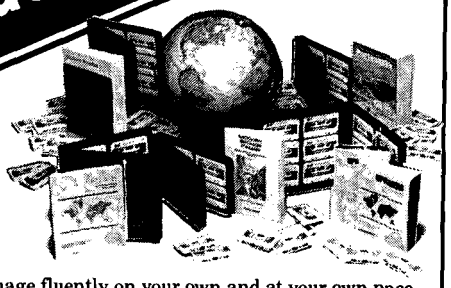
The program includes 3 cassettes and accompanying manual. Order #S23720, $39.50.

Learn to Develop Your Vocabulary



It's a known fact that there is a high, positive correlation between having a good vocabulary and career achievement. This unique program will give you the power words you need to increase the effect of your spoken and written communications. You'll add over 2,000 important words to your vocabulary, as well as improve your reading, writing, and speaking. Additionally, you'll learn special techniques that will help you to remember and use the new words correctly.

Course consists of 5 cassettes, 48-page workbook, and a set of recall cards containing pronunciation keys and brief definitions. Order #S01975, $59.95.



Learn a Foreign Language

Learn to speak a foreign language fluently on your own and at your own pace with what are considered the finest in-depth courses available. Most were developed by the Foreign Service Institute for the U.S. Department of State for diplomatic personnel who must learn a language quickly and thoroughly. Emphasis is on learning to speak and to understand the spoken language. A typical course (equivalent to a college semester) includes an album of 12 to 18 audio cassettes, (15 to 24 hours), recorded by native-born speakers, plus a 250-page textbook.

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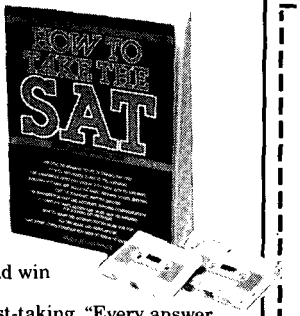
Learn the Secrets of Successful Writers

Learn the techniques and secrets of success of famous authors. Audio-cassette program by long-time teacher and nationally published writer Elizabeth R. Bills provides tips on how to get started as a writer, begin a story, write a magazine article, and more! Plus — a bonus techniques cassette by famed science-fiction writer A.E. Van Vogt. Six audio cassettes in all. Order #S23350, $49.50.

Learn How to Take the SAT and PSAT



This complete home-study course is guaranteed to improve the test scores of *any* college-bound student. It consists of a 372-page book and 2 audio cassettes that carefully guide the listener through the text. The course was created by Marcia Lawrence, whose instruction has helped thousands of high-school students maximize their SAT scores and win acceptance by the college of their choice.

This course actually teaches the *techniques* of test-taking. "Every answer is built right into the test," says Marcia Lawrence. "I show the student how to dig it out." She shows the student how to spot key clues, how to eliminate wrong choices, and how to zero in on the right answer — time after time. Order #S17038, $26.95.

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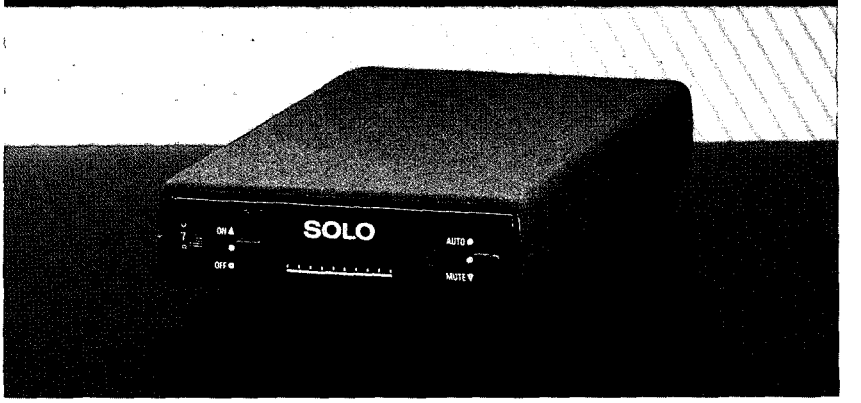

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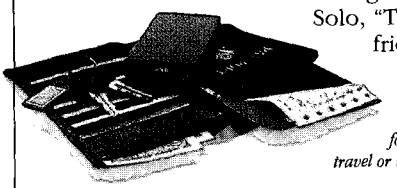

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